HOSPITAL RECREATION

NO. 11

January
1954

THE NORTH CAROLINA RECREATION COMMISSION

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HOSPITAL RECREATION

a report of

THE FIRST SOUTHERN REGIONAL INSTITUTE

ON

HOSPITAL RECREATION

Sponsored by:

The North Carolina Recreation Commission.

The National Recreation Association.

The Hospital Division of the American Recreation Society.

The Hospital Division of the North Carolina Recreation Society.

The Bureau of Recreation—Extension Division of the University of North Carolina.

and held at the

University of North Carolina **Chapel Hill**

May 21st, 22nd and 23rd

1953

Bulletin Number 11

Printed by The North Carolina Recreation Commission
Education Building Annex
Raleigh

Introduction

Harold D. Meyer, Director of the Conference

This Hospital Recreation Institute was the first of its kind held in the Southern Region. More than a hundred delegates from seventeen states gathered together for a three day intensive institute related to this rapidly growing field and added effective knowledge for its future development. The papers presented were high in quality and the general discussions denoted the fact that Hospital Recreation has grown up and today represents one of the most stimulating and challenging contributions of Recreation in the contemporary scene.

The program was formulated by a group of leaders representing the sponsoring agencies. The American Red Cross and the Veterans Administration made rich contributions to the Institute program and its leadership. Thanks is extended to all those who participated on the program and to the delegates who shared in the general discussions.

The Institute was opened by welcome remarks from three of the University's leaders—the Chancellor, the Director of the Extension Division and the Director of the Memorial Hospital. While the program was full, there were opportunities for wholesome get-togethers in sharing experiences, renewing friendships and becoming acquainted.

These proceedings are printed by the North Carolina Recreation Commission. They come to the leadership in the hope that they will add richly to the growing volume of knowledge in this fascinating field and will play a part in its further expansion.

As the general field of Recreation grows in importance, the divisions of special interest find greater significance in bringing the values of Recreation to special needs. The place of Recreation in administering to the ill—both as a social force in daily living and as a scientific factor in therapy is gaining solid foundation as a *must* in social well-being. Hospital Recreation holds great prospects for the future—its growth and its contributions are limited only by its leadership. Intelligent leadership can steer the way in promoting maximum results. The future is bright for Hospital Recreation. May its leadership accept the potentials involved and rapidly move forward to new adventures and the realities of achievement.

PROGRAM

FIRST SOUTHERN REGIONAL HOSPITAL RECREATION INSTITUTE

Thursday, May Twenty-First

MORNING:

10:00—Registration

11:00-12:30—First General Session

Harold D. Meyer—presiding.

Invocation

Introductions

Welcomes: Robert B. House, Chancellor of the University of North Carolina, Chapel Hill

Robert R. Cadmus, Director, North Carolina Memorial Hospital, Chapel Hill

Russell M. Grumman, Director, University Extension Division, Chapel Hill

A. "The Situation—Hospital Recreation"

W. H. Orion, Director Recreation Service, Special Services, Veterans Administration, Washington, D. C.

B. "Overall Trends and Practices in Hospital Recreation"

Lillian Summers, National Recreation Consultant, The American National Red Cross, Washington, D. C.

AFTERNOON:

2:00-3:15—Ralph J. Andrews, Director, North Carolina Recreation Commission, Raleigh—presiding.

"The Basic Philosophy of Recreation"

Charles K. Brightbill, Professor of Recreation, School of Physical Education, University of Illinois, Urbana.

2:00-3:15—"General Application of the Philosophy of Recreation in Hospitals"

Panel—W. H. Orion, Leader

Discussion

3:45-5:00—Dr. Roy R. Norton, Director, State Board of Health, Raleigh—presiding

"The Meaning and Significance of Illness"

Dr. Paul Haun, Clinical Director, The Bowman Gray School of Medicine, Graylyn, Winston-Salem, N. C.

"The Effect of Illness on the Individual"

Dr. George C. Ham, Head, Department of Psychiatry, North Carolina Memorial Hospital

Discussion

EVENING

8:00—Group Sessions

A. State and Private Hospitals

C. N. Carroll, Director of Recreation, State Hospital, Raleigh—presiding.

Dr. Ellen Winston, Commissioner of Public Welfare for North Carolina, Raleigh—Coordinator and Planner.
Mrs. Beatrice H. Hill, Consultant to Recreation Rehabilitation Service, City of New York—Consultant.
Rev. Charles Hubbard, Member North Carolina Recreation Commission—Summarizer
Panel Members:
Dr. Marion M. Estes
Mrs. W. K. Beichler
Thomas I. Hines
R. P. Pierce

B. Federal Hospitals
C. C. Bream, Jr., Chief, Recreation Division, Recreation Service, Special Services, Veterans Administration, Washington, D. C.—presiding
Discussion Topics:
(1) Personnel Standards and Qualifications
(2) In-Service Training
(3) Supervision
(4) Open Discussion.

Friday, May Twenty-Second

MORNING:

9:00-11:00—Oliver K. Cornwell, Head, Department of Physical Education, University of North Carolina, Chapel Hill—presiding.
"Personality Growth and Development"
"The Effect of Recreation on Personality Growth and Development"
Betty McConnell, Recreation Consultant, Southeastern Area Office, American Red Cross, Atlanta, Georgia.
Alice Moran, Field Director, American Red Cross, Fort Bragg, North Carolina.
Discussion

11:30-12:30—"Hospital Administration Looks at Recreation" Dr. James W. Murdoch, Supt. State Hospital at Butner

AFTERNOON:

Group Sessions

2:00-3:30—"How Can Recreation Needs be Discovered and Met in Hospitals?"
(1) Methods of discovering needs and interest through referrals and patient contact.
(2) Factors involved in meeting needs, including the medical, physical and leadership aspects.
Madolin Cannon, Recreation Consultant, Eastern Area Office, American Red Cross, Alexandria, Virginia.
"The Evaluation of a Good Hospital Recreation Program"
E. H. Pratt, Area Director, Special Services, Veterans Administration, Atlanta, Georgia.

3:45-5:00—"Swap Fest"
Edgar W. Johnson, Chief Therapist, Department of Physical Medicine, Graylyn Hospital, Winston-Salem.

(1) New Program ideas
(2) Ideas for special groups
(a) Neuropsychiatric—markedly disturbed
(b) Tuberculosis
(c) Crippled Children
(d) Orthopedic
(e) General Medical and Surgical
(f) Others
(3) Ideas for bedridden patients

5:00—Tea—Planetarium State Dining Room
Guests of the University

EVENING:

7:30—Harold D. Meyer—presiding
Group Singing
Address: "Recreation in the Contemporary Scene"
Charles K. Brightbill
Address: "Recreation and Rehabilitation"
Mrs. Beatrice H. Hill
Hospital Recreation Stunts

Saturday, May Twenty-Third

MORNING:

Raymond Gould, Associate Professor of Social Work, University of North Carolina—presiding

9:00-10:30—"Recreation Leadership"
Marian Preece, Field Representative, Southeastern Area, National Area, National Recreation Association, New York

10:40-12:00—"The Volunteer in Hospital Recreation"
C. C. Bream, Jr.

12:00-12:30—Summary

ADJOURNMENT

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REG. NO. 416

Philosophy of Recreation

Charles K. Brightbill, *Professor of Recreation*,
University of Illinois, Urbana, Illinois

I am honored, indeed, to be asked to speak to this professional conference on the topic, *Philosophy of Recreation*. I say "honored," because philosophy is concerned with "wisdom," and recreation with "living." This is a large order any way your view it. Philosophy has been called by some "common sense in a dress suit" and I realize that logic can sometimes be not much more than an organized way of going wrong with confidence. As I see it, the only point in discussing the philosophy of recreation is to cast more light upon a problem which is of mutual professional interest to all of us; but also I think it is of tremendous social significance to all of mankind. If we are to be intelligent at all about this, two things are necessary:

1. We must grasp the nature of *recreation*, understand its general character—know what it is.

2. We must understand its importance and appreciate its significance to individuals and to society.

I suppose that when the word "recreation" is mentioned a hundred different ideas come to the minds of a hundred persons. This is because our individual tastes and desires vary so greatly when it comes to things which seem to us to be pleasant, enjoyable and satisfying. And isn't it wonderful to have it that way? It might be nice for the manufacturers of pleasure boats if we all liked sailing, but I hate to think of the traffic on the lakes and waterways. One man's work is another man's play. Indeed a given activity for the same individual may be both recreation and work at different times. So it is very clear that the range of humanity's recreation is endless and we head toward disaster every time we try to circumscribe recreation or attempt to "fence it in." To define recreation as a list of activities is like trying to catch the rainbow in a landing net. But it would be equally stupid to try to pin point recreation in terms of the environment in which it occurs. We all realize, I think that the use of free time can be organized or unorganized and partaken by individuals or entered into by groups. It can be an uplifting and constructive or degenerating and destructive. But the kind of free time use which we have in mind, that is recreation, is always constructive because it is an outlet for emotional and creative desires which lead to productive, satisfying and socially acceptable channels!

While we may be unable to place our finger upon any one endeavor and say "this is recreation," recreation does, nevertheless, possess definite characteristics. We can agree that recreation has no primary incentive other than the satisfaction and enjoyment which come from it, although it does, in fact, have many rewards. We know, too, that recreation must be voluntarily sought and that it cannot take place in the absence of personal interest. It cannot be superimposed and it cannot be regimented. It is quite like the scoutmaster, who, upon stopping his scouts in the middle of a hike said, "Boys, this is the hour for rest and relaxation and I do not want to see any shirking." What is more, recreation and play are universally practiced and universally sought. They know not age or race, or custom or country. The kitten with the ball of string, the colt romping in the field, and

the child in the sand box are all at play. The yodelling Bavarian, the kite flying Siamese and the skiing Norwegian as well as the ball playing American are all engaged in recreation. Paradoxically, recreation is so much a part of everyone, so much a physiological and psychological need that there are many who mistakingly think it superfluous. If one is ever tempted to question the essentially of recreation he needs only to think of how drab would be the world without it. Or, if this isn't enough, then I suggest that you try to molest either the adult or the child who is busily engaged in his favorite hobby or play and you will soon see how essential the hobbyist or player considers it. Joseph Lee wisely noted that "your nine year old boy does not lie awake at night wondering about his arithmetic—no; the chances are that he is speculating upon his chances for making the neighborhood baseball team!"

It seems to me that in order to understand the significance of recreation, it is not enough to know what it is. More importantly, exactly what does recreation mean in the lives of men and the affairs of humanity? Let us first look at recreation and the individual. Nothing bothers me more than to hear the cynical retort— "Recreation? Look, bud, I've got to earn a living, I am not in business for my health or fun." Well, all I have to say is that if one is *not* in business for his health and wellbeing, he ought to change his business. Is there something morally wrong in learning for the sake of learning, in relieving nervous tensions, in reducing internal frictions and in exercising our God-given potentials to create? Sometimes I am inclined to believe that mankind would be better off if we were less serious about economic and political affairs and more serious about "living." And do not think for a moment that I am talking about taking things easy, loafing, or idling away one's time. To this the ancient Romans had an answer with their proverb, "It is difficult to rest if you are doing nothing."

The contributions which recreation can make to the positive development and the full living of individuals are, of course, countless. Permit me to comment upon just a few of the more important ones—namely, health, education and freedom.

Health

Without health, of course, there may be life, but it cannot be positive and exhuberant! Actually, there is good reason to believe that recreation may be the most important factor in keeping one healthy. Those who work with the ill and disabled, know well the influence of recreation upon recovery even though they may be unable to measure its impact. This is a point which needs little if any elaboration among hospital recreation leaders.

Recreation for many people is their chief form of relaxation. For those wise people, recreation helps build a world for them apart from their jobs. The problems of business can vanish on the golf course and the family budget worries lost in a Beethoven Symphony. What is more, recreation is a palatable way of reconciling life with our dreams because it both releases and disciplines the imagination. For years men have looked for the mythical "Fountain of Youth"—tired minds and bodies need rejuvenation. And where you find refreshment you will also discover change. Life balks at repetition. Change can prevent fatigue. Watch young people any day and you will see great variety and change. One day last summer my 14 year old

son swam in the morning, played golf and built a dog house in the afternoon, played his accordion after dinner, set up our badminton equipment in the back yard at twilight and then asked me if we could find something different to do for fun the rest of the evening. His life isn't empty. Recreation to him is a refreshing, ever-changing multiplication of human delights.

The stimulus which certain kinds of recreation gives to physical health in the form of muscle development, blood circulation and respiratory activity is almost too obvious to mention. Motor action, of course, is essential and so is laughter which can also be relaxing, even where it is at your own expense. That recreation can restore organic balance has been demonstrated repeatedly in war as well as in peace. The combat area service clubs, the armed forces recreation rest centers, the special services mobile companies all support this fact.

As our good friend, Ott Romney, has often said, "this is an age of specialization and thus, unfortunately, fragmentation." That is correct. Modern specialization in almost every phase of our living leaves gaps in our personalities and in our lives. But even if work were not specialized, it could not indefinitely maintain one's balance. Recreation is a sure way of restoring organic balance distorted by the fast and furious pace of our living. As a young housewife said recently, "I have been so busy getting meals that I have not had time to learn to cook." Yes, I think we can agree, that in this atomic age we "worry" too much and we "hurry" too much—recreation is a good way of curbing both and simultaneously changing the "nibble" at life into a sizable bite! No less than the Royal Bank of Canada is authority for statement that—"There are four main components of life from adolescence on: work, recreation, physical and mental health. When these four are balanced, and lead us along creative lines, then life can be very satisfying and enjoyed longer." Certainly, because recreation *does* revitalize, rejuvenate and refresh, it is not only an avenue of escape from our problems and reverses: it can also be a fresh start. Cervantes put it accurately when he observed, "the bow cannot always stand bent, nor human frailty subsist without some lawful recreation."

Education

Now as far as learning is concerned, I guess that education began when Adam stubbed his toe maybe while he was seeking a little recreation. But if we can say that learning springs from all of life's experiences, then recreation is loaded with educational possibilities. *Anybody* who knows *anything* about life and its problems—can tell you that the greatest lessons are not by any means always taught in the classroom! The desire and curiosity to delve into the unknown lie at the base of *all* educational development! Look you then I say at the world of recreation in the most palatable of forms? Does recreation open the door to greater appreciation of the cultural arts? Does rich experience many times grow out of the things we do not because we *must* do them but just because we *want* to do them? If recreation does not sharpen skills then my friends attempt to bring bare canvass to life in oils is hogwash in its most elaborate form and my neighbor's ability to tie a fly is a prime example of civilized loafing. Oh no. Recreation is not only an escape from the toil of education. It is a revitalizing element in the process of education itself.

I say to you that if it is the objective of education to teach the ways of democratic living, to understand the world and life about us, to attain health and emotional stability, to understand and enjoy the arts, to develop constructive skills and to stimulate intellectual, personal and social growth—then recreation has enormous educational values. It is not even too much to expect that through recreation may some day come the ultimate in the hopes of the educational world—that is, a full realization that learning is far more important than teaching!

Freedom

Health and education are, of course, indispensable, but they mean little and can accomplish less without *freedom*. Somerset Maugham said, "There are two good thing in life—freedom from thought and freedom from action." Every real American supports these truths. Indeed, both our forefathers and our sons have defended freedom on the field of battle. Is it not strange, then, that while we are prepared to lay down our lives to protect this franchise, once having protected it so many of us are unwilling to exercise it. I do not refer to freedom of speech or religion or freedom of the press. I have in mind the regimentation, the routine, and the standardization which is forced upon us in a complex society. Man can be lost in the midst of plenty, and confined in the absence of chains. The woes of this modern age have been written and spoken in many ways, but none I think more appropriately than by Richard Armour in the *New York Times* when he said:

> Service it seems, is now well on the way,
> To achieve its considerable aims for us:
> First machines to provide us with leisure and play,
> Then machines to play various games for us.
> When machines do our work and machines do our play,
> We'll rejoice, for we'll then be in clover.
> We'll have nothing to do all the livelong day—
> Till machines that do nothing take over!

If there is one strong citadel against the imposition of all the things we "have to do" and the stereotyped existence of a machine world, it is recreation and recreation alone! Where else can there be unimpaired, endless freedom of thought, freedom of action and freedom of choice? Where else is the outlet for uninhibited opportunity to express and discover, to roam when and where we please and to give life to our eternal desire to create?

It is really amazing the extent to which recreation animates, recognizes, depends upon and generates the dignity and growth of the individual, something which I think we can agree is the *main* pillar of freedom. The basic human appetites for pursuits which nurture the soul, enlighten the mind and refresh the individual can be stimulated but they cannot be enforced. Unless the desire to move in that direction comes from within the individual, there can be no real expression and thus no joy. As the individual—of his own volition—seizes upon the opportunity to express himself freely and to create as he wants to create, he develops knowledge and an awareness of his ability to accomplish. This consciousness of being able to achieve and the building of self respect are the *first* rungs on the ladder of individual dignity! There is nothing to compare with the glory reflected in the eyes

of the child who has read his first word, caught his first fish or whistled his first tune. Individuality is sparked by an appreciation of one's own capacity to accomplish. The shaping of personality and character, prerequisites to individual dignity, and hence freedom, occurs to a large extent in free time used recreationally. Unless the mind is free to chart its own course with the opportunity for full expression, there can be no individual dignity, no democratic life and no real freedom.

I have said many times that the breadth and depth of recreation are at one end the same time its greatest liability and its greatest asset—liability in the sense that because it is as comprehensive and as significant as life itself, it is difficult, if not impossible to define. It is an asset because, it is so extensively and eternally with us. Perhaps I cannot be entirely sure of the "why" behind recreation, but I *am* certain of its existence and its purposefulness. I believe it to be one of humanity's main approaches to the Greater Life. I believe its meaning and purpose are pressed toward that which helps life grow—something to satisfy the imagination and stir the soul, making the life which *is* lived and the life one may *hope* to live— real, worthwhile and abundant.

RECREATION IN THE CONTEMPORARY SCENE was the title of a second address given by Charles K. Brightbill. Here are excerpts from his remarks.

We cannot look at recreation today without looking at contemporary U. S. A., its people and its problems. And what do we see? We see a society which is not so surprisingly different in many ways from the generations which have gone before. People still seek good homes, healthier bodies and better living conditions, as they have down through the centuries. Certainly, the standard of living is higher and folks live longer but the same machines which have freed man from physical toil have, in one sense, also enslaved him. We have not found the perfect solutions to our social problems and we still search for happiness and peace of mind. Jet propulsion has not brought us any closer to zestful living and nuclear physics has not reconciled political idealogies. Aside then from the issues and problems which currently influence every phase of our living—butter versus guns, opportunity versus security and a sound economy versus inflation, with all of its headaches, these conditions provide the setting for recreation in the contemporary scene.

And what about recreation in the United States, particularly organized recreation, the way it is and perhaps the way we would like it to be. There are many developments, of course, may I select a few of them for your attention:

I. THERE CAN BE NO DOUBT THAT THERE IS MORE WIDESPREAD UNDERSTANDING AND ACCEPTANCE OF RECREATION AS BEING AN ESSENTIAL IN THE LIVES OF PEOPLE AND THE COMMUNITIES THAN EVER BEFORE.

I. Great increase in the number of tax supported recreation systems—up in the 1000's and adding 100 or more each year—small towns and counties as well as cities from coast to coast—more successful referenda and more bond issues and higher budgets.

2. Expanded programs of the voluntary agencies—35 to 40% of community chest budgets go for recreation.

3. Industrial recreation development—20,000 plants spending $265,000,000 a year on recreation and increasing year by year.

4. Startling growth of recreation in hospitals—more important, increasing recognition by the medical profession—the American Medical Association and the American Psychiatric Association.

5. Increasing recreation role of the states—(pioneering states of North Carolina, Vermont, California and now Washington)—Bills for state recreation commissions pending in New York, Pennsylvania, Ohio, Connecticut, Michigan, and my State of Illinois—Indiana revising its park and recreation code—Alabama recreation training for rural school teachers—Missouri's community recreation forums—and Louisiana adding recreation to its parks commission.

6. Federal Government and recreation—A Federal Recreation Service is perhaps one of the movement's greatest needs and a favorable climate of opinion, through the new Department of Health, Education and Welfare, is evident.

7. International aspects—activities of UNESCO (new International Office of the National Recreation Association—State Department's Exchange Program—and the developments of recreation through the ILO and its Geneva Conference.

II. THE GROWTH OF RECREATION AS A MATURING PROFESSION IS A MOST SIGNIFICANT DEVELOPMENT ON THE AMERICAN SCENE.

1. Recognition of recreation as a noble, identifiable profession in its own right whose objectives are compatable with the finest concepts of American democracy.

2. More than 65 colleges and universities offering major undergraduate curricula.

3. Closer integration of recreation with the humanities and the social sciences. Graduate programs—assistantships and fellowships—S. Africa, Egypt, Philippines, Japan, Finland, etc.

4. Higher salaries (and its about time)—with no more difficult work.

5. Southern Regional Study of Recreation Personnel needs—College Recreation Association and its activities—Jackson Mill and Pere Marquette reports, National Recreation Association Personnel Committee.

6. Certification and identification activities and trends in various states—never quite reach professional status so long as a barber must be certified, plumbers registered but anyone can practice recreation.

7. We are slowly but surely developing a body of practical literature.

8. Making inroads on research, but not enough—knowledge precedes service, and theory precedes its application—if recreation lags behind in scientific knowledge and controlled study, it will bog down—we cannot yet claim that recreation is a field in which the finest minds are at work—not is recreation intrinsically easiest for applying the scientific method—but recreation is an unbeatable laboratory for research for it encompasses all of humanity's finest interests—in absence of research our resources are dissipated and learning is handicapped— recreation is hanging too long on the reasearch coat tails of other disciplines.

III. WE CAN BE GREATLY ENCOURAGED BY THE FACT THAT THERE IS INCREASING CROSS FERTILIZATION BETWEEN RECREATION AND OTHER FIELDS.

1. Recreation does not stand alone, it is partnership with other needs of the individual and community—decent homes, sounder health and better schools are not enough, need chance to grow socially physically and culturally—character and democratic living are enhanced as much by recreation as they are retarded by community disease, shabby housing and anti-social behavior—there must be chances for wholesome use of free time—not any free time, but free time which accompanies security from totalitarianism, from unemployment, from want and fear.

2. Recreation is at its best on the team approach—communities are served by case workers, public health people, educators, city planners and group workers as well as recreation leaders and hospital recreation workers must work in connection with doctors, nurses, and social workers if the best results are to be achieved.

3. In our communities we must look above as well as around—take cues from the cultural arts—symphonies, music schools, dramatic activities, art institutes, museums and the like—and get out of the elementary level of the kindergarten concept of recreation as but a playground movement.

4. Allied public, cultural and social service fields are closer than you think.

IV. THERE ARE MANY OTHER SIGNIFICANT DEVELOPMENTS ON THE AMERICAN RECREATION SCENE. WE ONLY MENTION A FEW OF THEM BRIEFLY:

1. A slow but inevitable recognition of the great need to educate for leisure—a responsibility of the home, school and church as well as the community—organized recreation is but a small part of the picture as far as impact of leisure on social fabric is concerned.

2. Careful analysis of current population trends to a balanced program—more activities for girls and women, more older folks programs, more attention given to people in satillite suburbs of the cities.

3. Great need for widening the tax base for financial support as illustrated in establishment of district and county recreation systems.

4. Liberalization of state and local laws providing a foundation for more extensive recreation services in communities and institutions.

Conclusion

Now, I'm not going to pass up the chance to get a few gripes off my chest which have bothered me about the recreation profession for some time—here they are:

1. I am afraid that as recreation workers, representing the finest of groups, institutions and agencies, we do not always measure up to the high purposes and ideals which our profession and organizations have set for themselves. This is because we are all subject to the frailties of humans. But it would pay handsomely, I am sure, if every once in a while we took our charters and constitutions off the dusty shelves and reminded ourselves of the high goals and worthwhile purposes we, or our predecessors set for ourselves.

2. Ever since I became interested in the problems of leisure and what wholesome recreation can do for people, I have wondered why we have tried to couch this noble effort in such terms as to make it almost impossible for a plain man to understand. Can we not say that we are trying to help make

boys and girls healthy and strong and honest and good without referring to it as a "positive influence on adolescent behavior patterns?" Can we not say that we are getting together to do a job which needs to be done without calling it the "coordination of the methodological integrating process"? Could we once again call a book a "book" and not a "frame of reference"? We cannot do good planning without public understanding. We have nothing to hide! Let us not sacrifice the interest of our lay brethren on the altar of high sounding technical terms and professional gobbledy gook.

3. Other than these, I have no "bones to pick" with my associates in the recreation profession. Our job is important and none is more noble. And it is exactly for this reason that we cannot afford to be oblivious of the times in which we live. We all know that we are at a critical point in history.

If as the British historian, Toynbee, has said, "Advanced societies tend to substitute license for liberty, irresponsibility for obligations, comforts for challenge and self-interest for brotherhood, then we must be sure, as we plan and provide for a richer life through recreation, that the dignity of the individual is enhanced, that tolerance is substituted for prejudice, that with the privileges and opportunities of democracy also come responsibilities and obligations, that giving of one's self in the cause of humanity is a truly magnificent experience and that disciplining of the mind and body in creative ways can bring with it personal satisfactions and adventure undreamed of which, after all, is the only real life worth living!

The Situation — Hospital Recreation

W. H. Orion, *Director,* Recreation Services,
Veterans Administration, Washington, D. C.

In discussing The Situation in Hospital Recreation it is necessary to review some of the unique features of this type work and to hold them in mind as basic considerations during this conference.

FIRST. Patients are in hospitals because they are, in varying degrees and combinations, physically, mentally, or emotionally ill or incapacitated. Consequently, whereas in general recreation one can expect a small percentage of participants to be in impaired health, in hospital recreation one can expect all to be.

SECOND. The patient population is not a homogeneous one—for such contrasting patient types as the paraplegic, tuberculous, blind and psychotic are to be anticipated.

THIRD. It is immediately apparent that with any population composed exclusively of patients there exists an ever-present possibility of irreparable damage to participants by the use of ill-chosen activities or methods. Because of this fact the choice of activities, methods, and techniques cannot be left solely to the discretion either of the recreation leader or of the patient, except as such choices fall within the limitation of medical dictation.

FOURTH. There is a continuous need for the adaptation of activities, equipment and procedures to the needs, capabilities and interests of participating patients.

FIFTH. Because the function of the hospital is to treat patients, physicians determine the specific objectives for patients participating in recreation,

individually and in groups. For the most part these same physicians rely heavily upon the specialized knowledge of recreation leaders in the selection of those specific recreation activities, methods, and techniques best suited to help achieve these objectives. No activity is scheduled without medical approval; no patient participates in such activities without medical clearance or prescription.

LASTLY, THE RECREATION LEADER IN HOSPITALS IS A MEMBER OF THE TREATMENT TEAM, A TEAM OF WHICH HE IS AN IMPORTANT MEMBER, BUT NEVER A CAPTAIN.

The foregoing, then are basic factors which contribute to the uniqueness of hospital recreation.

The Situation—Historically

Recreation for the ill and injured is not new. There are little jewels of statements to substantiate this fact coming throughout recorded history. But the story I like best is that of Florence Nightingale who, in May 1855, after strenuous opposition opened a small reading room for men able to walk but not able to leave the hospital. The authorities feared the men would get above themselves if they read instead of drinking, and Miss Nightingale was accused of "destroying discipline." However, their conduct was excellent. She found many of the men could neither read nor write, and asked if she might engage a schoolmaster. This was absolutely refused. "You are spoiling the brutes," Lord William Paulet told her.

When Lord Paulet was replaced by General Storks, Miss Nightingale found an enthusiastic collaborator; working hand in hand they brought discipline and order to the Barrack Hospital and its neighborhood. In September of 1855, a large recreation room for the army was opened with the aid of private funds. Miss Nightingale wrote to England for copybooks, maps, puzzles, chessmen, pictures and books. In short, Miss Nightingale was forcing the importance of the morale and mental well-being to the soldier's health on his officers. She was truly treating the "whole man," and this was in 1855.

We have our Lord Paulets in medicine today. And they say to us in their own manner, "You are spoiling the brutes." Fortunately, however, we have many Florence Nightingales and medical leaders of the type of General Storks, and these folks are making it easier to treat the whole man today than it was some years back.

We are all familiar with the more recent history of recreation in hospitals. World War I brought forth an Army directive authorizing the American Red Cross to serve in military hospitals. The Works Progress Administration staffed certain hospitals with recreation workers. The Veterans Administration continued the work of its sports and recreation technicians. World War II brought forth many new treatment procedures and among them, gave added stature to recreation in rehabilitation.

The Situation Regarding Types of Hospitals

For the purposes of this conference, I would suggest that in discussing hospitals we exercise care to think in terms of all hospitals, not only the military, or the VA, or the state or tax supported institutions, but to private hospitals as well as to hospitals catering to any particular age group. In other words, it would be well to base our discussions on the over-all situ-

ation because recreation programs can and do exist in every type of hospital although it is true that in some the programs are meager.

The Situation Regarding Types of Patients

It follows that every type of patient may well be discussed in the course of this conference although it is, and has been, obvious that our greatest concern must be with the so-called "long term" patient, for the hospital is his life,—and his home. As regards this situation in the Veterans Administration it can be stated that we have many thousands of long term patients throughout the United States, to be found in our general medical, TB and NP hospitals. Also there are thousands of men in our domiciliaries, nearly all long-time members. With our aging population it would appear that recreation is destined to play a prominent part in the on-coming field of geriatrics.

The Situation Regarding Program Content

It is most important, I feel, that we establish in our minds at least some of the items about which we are to talk so far as program content is concerned. What goes to make up a hospital recreation program? There is much thinking abroad that hospital recreation is composed exclusively of one or two elements, the visit of a celebrity, for instance. As fine as visiting celebrities may be, they constitute a mighty small part of a 365 day program, yet over publicity of this phase leaves a wrong impression.

At the expense of some possible debate or disagreement I am listing ten categories of recreation which may play an important part in the hospital recreation program; suitable for use in a balanced program for active, passive or spectator patient participation:

Adapted Sports, including Aquatics
Music-Drama-Art
Recreational Reading
Group and Social Activities
Multichannel Radio Programming
Hobbies and Crafts
Hospital (patient) Newspapers
Writing projects
Motion Pictures (on and off-ward)
TV Scheduling

All of these activities are currently playing a part in hospital recreation. Only a comparatively few hospitals are using the entire list today; nor is the need for all of them indicated in every hospital.

In view of the fact that TV is a comparative newcomer, results of a recent VA-wide survey might prove of interest. Briefly these were the findings: (a) Active participation in recreation activities appears to have greater appeal to patients than TV viewing, if a choice between the two is available. Exceptions included top sports events and nation-wide programs such as the inauguration. (b) That TV viewing is considered highly desirable for all types of patients, except the seriously ill.
(c) That our medical staffs treating emotionally disturbed patients strongly emphasize the value of properly conducted TV viewing as a positive therapeutic adjunct. For keeping patients in touch with the community and the

outside world, for promoting resocialization, for providing much needed entertainment and topics for discussions among patients, and for many other reasons, TV viewing is deemed to be of assistance in the treatment of NP patients. (d) That no restrictions on types of TV programs to be viewed need be exercised for other than NP patients. (e) That control of TV program content and TV viewing hours are not considered serious problems. (f) That TV viewing has been successfully integrated into the recreation program.

The Situation Regarding Personnel

It follows that where we carry on the activities just enumerated, that personnel for hospital recreation must be composed of workers thoroughly qualified to lead in these aspects.

The basic work of leadership in the Adapted Sports and Aquatics program, for instance, must be conducted by qualified physical education graduates and their training must be considered a never ending obligation. Several universities are readjusting courses for preparation in this field.

There seems to be a fairly adequate number of persons trained quite adequately for the arts and crafts work. The same is true for projectionists operating 35mm and 16mm programs.

The training of music leaders for hospital work is progressing rapidly at several institutions. Workers in the field of hospital music are presently among our best trained personnel.

If we are to make the best use of multi-channel bedside radio systems we must have radio program directors who are skilled at this work. Such persons must be able to develop patient radio production groups, organize hospital originated live programs, hospital originated transcribed programs, re-broadcasts and tape recording work. Only a few currently have these abilities.

Need for better training is evident for those who are to plan and furnish leadership for social activities such as dances, parties, games, tours, outings, etc. These are the workers often spoken of as recreation technicians. Qualifications for the positions have not been adequately developed, although the responsibilities for their patient relations are great.

Civil Service, at all levels of government, is aiding in the solution of the recreation leadership problem. We must be active in this field. Constant re-evaluation is clearly indicated if real progress is to be made. Currently our standards are too low to assure us continued acceptance by the medical profession.

No discussion of the hospital recreation personnel problem would be complete without reference to the volunteer. Definite programs of recruitment, screening, training and placement of volunteers are now operating throughout the country. The services rendered by volunteers are of a supplementary nature to that of the staff. Good volunteers want and deserve good planning and good supervision on the part of hospital personnel. Volunteer workers bring so much that is fine to the hospital that we cannot afford to be without their services, in fact we could not do a top job without them.

The Situation on Nomenclature

What is therapy? Should we use the term? Are recreation workers therapists? Actually it appears that among medical men there are two schools

of thought on the interpretation of the word therapy. One is that the doctor himself is the only therapist. The other believes that everything that happens to the patient while he is in the hospital is therapy and that the personnel directing patient activities are therapists. More and more we hear the word therapy in connection with sports, recreation, music and other hospital activities. Higher authority will recognize hospital recreation for what it is in due time.

It was interesting to note in the current issue of *Recreation* two articles having reference to the problem of nomenclature. In Dr. Stevenson's article, "The Spice of Life" he indicates that to call recreation a therapy is a travesty, but goes on to give some solace to those who cause the travesty a ligitimate (financial) reason for so doing. In the same issue of *Recreation,* and a few pages further on, Mr. Davis makes reference to his Clinical Applications of Recreational Therapy.

My recommendation for the time being is that we do an outstandingly fine job on the treatment team and let the nomenclature catch up with us.

The Situation Regarding Professional Organization

The American Recreation Society with its active hospital recreation section is providing professional leadership in various parts of the country for a sizable group of workers. National and local conferences are held regularly and the Society furnishes a quarterly publication as well as special bulletins.

The National Recreation Association through its monthly publication provides many articles of interest to hospital recreation workers. The Association is giving active leadership to this phase of recreation and has recently published a fine booklet entitled "Starting a Recreation Program in a Civilian Hospital," by Beatrice H. Hall. The Association's national annual meeting also deals with hospital recreation problems.

The American Association for Health, Physical Education and Recreation maintains a Recreational Therapy Section in its recreation division and gives a column or more each month to the subject in its Journal. Section meetings on Recreational Therapy are held during the Association's annual conference as well as its District meetings.

The National Association of Recreation Therapists, the American Association of Rehabilitation Therapists, The American Association for Physical and Mental Rehabilitation, and others, offer additional outlets for professional activity both locally and nationally.

Presently there is much thought being given to the development of an over-all organization of professional people engaged in the adjunctive therapies, including recreation, through which all therapists could join in a single professional group.

The Situation Regarding Recognition

Medical recognition does not come easily. Professional recognition for hospital recreation services may come, in time, much as was the case of Medical Social Service. Ida M. Cannon states in her book, "On the Social Frontier of Medicine," that, "The evolution of attitude on the part of the medical staff toward the Social Service Department at the Massachusetts General Hospital, went through these phases—resistance, tolerance, partial recognition, and finally full acceptance and establishment as an official and necessary department of the hospital, a responsibility of the Hospital Trustees

to support." A service, not a charity. Such recognition took many years to achieve.

Our situation currently, it seems to me, is very spotty. Actually as one moves about the country instances may be found where each of Miss Cannon's steps may be found viz., resistance, tolerance, partial recognition, and full acceptance. It is fun, it is challenging and it is hard work being in a developing field of our kind. Hospital recreation workers the country over are constantly evaluating their programs so that ultimately full medical acceptance will be forthcoming.

Summary

In closing, I should remind you that all of the items I have commented on in this paper will be discussed at far greater length during the remainder of this day and the following days of the conference.

To sum up The Situation—Hospital Recreation, I should have to say that great progress in this field has been made during the past ten years; that the work shows evidence of expansion and growth; that the need for better training is great; that evaluation and research are pressing problems; and that the need for hospital recreation is from day to day being recognized by more and more doctors, particularly those having to do with long-term patients.

As technicians working with the ill you at the hospital level are key people in this fine undertaking. You have been faithful, professional, conscientious, sympathetic in the proper way, and enthusiastic in your pioneering efforts. I salute you—and wish you every success.

Overall Trends and Practices in Hospital Recreation

Lillian Summers, *National Recreation Consultant,*
American National Red Cross, Washington, D. C.

We have heard from Mr. Orion the development and progress of Hospital Recreation in recent years. I would like to discuss with you the effect that overall plans, trends and practices have on the future. Where are our sights trained? What does the horizon look like to you—because to each person, depending upon his situation, the horizon will present a picture that will differ slightly from what another person may see. Some of these future sights are undoubtedly colored by practical facts of the present. How much staff you have; what operating budget you have to work with; the type of patient; the understanding of the hospital administration; volunteers who are available to assist. How much time do you have to give to interpretation; to training; and to planning. These are all factors that confront us so that often we're placed in that same old position of not seeing the forest because of the trees. So during these few days we have together, let's push aside those trees and peer out into the broad overall situation to which each person here is making a contribution.

It's part of human nature to seek recognition and people in recreation are no exception to this desire. We say that recreation gives an opportunity to people to find wholesome recognition in one way or another by develop-

ment of skills, talents, and as recreation leaders we seek recognition for our profession. We want most especially recognition from the medical profession for our contribution to the well being of the patient, in our assistance with his recovery. We know that such recognition comes slowly as the part of recreation in the hospital is demonstrated. And there are many examples of such recognition. A number of Veterans Administration publications concerned with hospital recreation bear the signature of members of the VA Medical and Psychiatric staff as authors or co-authors. The *May* issue of Recreation Magazine carries an editorial by Dr. George Stevenson. Dr. Bernard Kahn, Psychiatrist, Oakland Naval Hospital, in a paper which he presented at the National Recreation Congress last fall, states, "To best understand how to use recreation as a therapeutic tool for the mentally ill or emotionally disturbed, it is essential to understand how normal people use recreation for emotional enrichments. From a therapeutic view in an institutional setting, recreation may be defined as a pleasurable flight from the immediate realities of tension inspired situations or conflicts."

In this situation as in others when the doctor has evidenced interest in the development and contribution recreation can make, there is a history of demonstration on the part of the recreation worker in showing, through daily examples, the part recreation can play in a hospital. As results are in evidence, interest and recognition come. Probably each of you have felt the thrill and excitement that comes when the doctor says, "That was an excellent program last night as far as patient reaction was concerned. We need more participation activities—the patients responded well and they all had a good night's sleep. The nurse reported there were no instances last night when she had to give special medications or quiet a disturbance." And it will be from an accumulation of such examples that the recognition we all want from the AMA and APA will come. The process is a slow one but that is to be expected. As more doctors and psychiatrists become aware of what we mean by recreation then we can expect an increase in their interest and recognition.

Recently I was asked to speak to a group of Military and Civil Service Medical and Psychiatric Social Workers at Walter Reed Army Medical Center on the subject "What is the Contribution of the Teamwork Approach to the Treatment and Rehabilitation of the Patient." I would like to quote one example used in this paper to demonstrate the teamwork approach and the contribution made by recreation. (Example stated orally)

There are other examples, many of them. It happens every day. But all too few of these examples are ever written. Which brings us to the subject of responsibilities of recreation workers. Oh yes, I know recreation workers are busy people—there are a lot of wards to be covered and the recreation hall programs must go on. And the visiting groups must find everything in readiness so the whole program will run smoothly. And the outside area must be considered—there's a croquet tournament today. And it's all true—there are too few people to get the job done. There are details—many of them. But with all these things there must be some time for the recreation worker to think, to write, or else how will others know what is being done? There is an increase in the printed word concerning hospital recreation but more, much more is needed. For often its been said that recreation people are poor

interpreters; we don't know how to sell what we are doing. It is because we get so busy with the activity side of recreation that we forget the other aspects? Whatever it is it behooves us to give some time and thought to the matter and to increase our means of communication and sharing of information. Most of you are familiar I am sure with the *Newsletter* of the Hospital Recreation Section of the American Recreation Society; the column on Recreational Therapy in the *Journal of the American Association of Health, Physical Education and Recreation*; and the *Inter-State News* published by Charles Cottle at Mississippi State Hospital. In addition *Recreation Magazine* as well as the *AAHPER Journal* have frequently used special articles concerning hospital recreation. The VA through their Special Services Information Bulletins publish a wealth of material concerned with recreation in VA hospitals. The American Red Cross publication *The Recreation Suggestion's Exchange Bulletin* includes ideas developed in that particular setting for which Red Cross is responsible, the Military Hospital, as well as other pertinent information. Each of these publications is playing its part and I'm sure we all look forward to the day when there will be an overall Journal of Hospital Recreation. That day may be far in the distant future but there is an important contribution being made today toward that future. We're growing toward it and I am convinced that as the field develops we can look for the demands of hospital recreation people for such a journal. But what hospital recreation people must realize that they are the ones who, either through their own writing or through their interpretation and arousing the interest of others, doctors, nurses, social workers and others working in the hospital setting, will make such a journal possible. Use the means we have today to publish material and some day the natural demand will create a representative journal of the profession.

Sometimes I think that we in recreation expect too much in too short a time. We look at journals from other groups—all the various medical and psychiatric publications—the various journals of Social Case Work—which are then broken down into Child Welfare—Medical Work—Psychiatric Social Work, etc. We forget that such development takes years. We forget to measure our own progress with the past in our own profession and tend, in my opinion, to compare and expect growth equal to other groups. If more often we measured our present with our own past perhaps we would find more encouragement. It's good to be ambitious—we want to be ambitious. But let's keep ambition within reason and not experience discouragement when we fail to secure all the recognition we feel is rightfully ours in this noble venture.

Do we find our roll as pioneers in a field somewhat difficult? If we do then let's think how long it takes in medicine for a new drug to be accepted. The years that are often involved in behind the scenes research before a new discovery is announced. The work, the heartbreak that is experienced before success is achieved.

What are we doing to experiment? To develop research? Quite a bit I'm convinced but perhaps we don't always recognize what we are doing as that. How many examples do we have? Here is one—an example of a referral by the doctor to the recreation worker is taken from a record of individualized recreation on a Neurosurgical Service.
(Example stated orally)

You are no doubt experiencing such examples frequently in your setting. Will an accumulation of such material provide us with data that may be related to reseach? It is difficult to set up measurements because of so many factors in addition to the type illness or disability—emotional—economic—educational—all enter into the picture—but we can provide examples of our accomplishments with individuals which should be invaluable in collecting material to add to our body of knowledge.

Role of Recreation in Rehabilitation

Mrs. Beatrice H. Hill, *Consultant to Recreation Rehabilitation Service,*
City of New York

Rehabilitation is perhaps one of the most abused words in the English language. What does this word mean?

Doctor Rusk describes Rehabilitation as, "The restoration of the handicapped, to the fullest physical, mental, social and economic usefulness of which they are capable."

We certainly all agree with this. However, at least in New York City, the term itself is very misused in its relationship to the handicapped and ill population of our large city. If, we are to accept Dr. Rusk's description of Rehabilitation in its entirety, then, why are the three Rehabilitation services of our city and one of our two private institutions in the main serving only patients, who will return to the community and achieve vocational and economic usefulness?

Is not true Rehabilitation the education of the handicapped or ill to achieve the fullest life possible despite physical limitations! To me, this would not be measured necessarily only in the patient's economic or vocational abilities, but also in his social and mental capabilities. It would seem to me that in addition to returning the patient to the community with economic ability, stress should also be put on the mental or social side of the patient's welfare! It is just as important to learn to live comparatively happy in institutional or home confined surroundings, as it is to learn to return and live a useful life in the community framework.

At the Institute for Physical Medicine and Rehabilitation, all of our patients are there to learn to live within the confines of their illness, with as well adjusted a life as is possible for them, despite their severe physical disabilities! At least 50% of our census will not go back to so called community or vocational usefulness. These 50% will either be institutionalized or home-confined for the remainder of their lives. Consequently, if they cannot learn a vocation, what can be more important than their learning to pass their lifetime with something that keeps them interested? For example: One of the boys at the Institute comes from a wealthy family in New Jersey. He is 19 years old. He dove off a diving board at Lake George last August and broke his back. He is still 19 . . . But, he will never move again nor will he die of his injury. Only a secondary ailment could possibly keep him from living a normal life span. His fingers have slight movement. Other than that, he is totally paralyzed. Consequently, you cannot develop his physical, vocational or economic usefulness to any degree, but you can try to develop his mental and social faculties to their utmost. He could be en-

couraged to develop love and appreciation of music, perhaps even creation of it. If possible, he could learn to enjoy literature and perhaps develop an ability to write. He could be encouraged to find some science or study to which he could devote his energies and mentality. Recreation, so far, has succeeded in finding one healthy interest for him, Ham Radio. Others, we hope, will follow.

The role of Recreation and Rehabilitation is often contradictory. For example: If the patient is returning to the community, recreation must not make the hospital or Institute such a gay, happy place that it might deter him from being motivated to leaving the hospital. On the other hand, for the patient remaining institutionalized or home-confined, his happiness and enjoyment should be the primary aim of Rehabilitation, and with him Recreation should be geared to whatever pleases him the most, whether it be standing on his head or learning a deep science.

Again, to quote Dr. Rusk, "Recreation is a valuable therapeutic tool. Many of the physical and emotional needs of the convalescent, chronically ill or disabled person can be met by a properly conducted program of therapeutic Recreation." There is need for such a program, not only in the Rehabilitation and the Psychiatric Hospital, but also in the General Hospital, especially those caring for chronically ill patients.

All of us here know that Recreation is a necessary part of the Rehabilitation Team. We also all know that all people need Recreation and all patients are people. Consequently, no matter what manner of Rehabilitation the patient is going through to adjust his illness or handicap, he needs guided or suggested Recreation.

For the Tuberculosis Patient, Rehabilitation may be retarded because he has excessive boredom and a lack of mental stimulation; He is concerned for the future of his loved ones and for their financial security, as anyone who is institutionalized might be; and, he may over-concentrate on his own illness. Also, typically, and for one or more of the above reasons, he may defy the physical limitations of his condition. He may even discharge himself from the hospital without medical approval and jeopardize his chances for an eventual cure.

Therefore, Recreation's part in the Rehabilitation of the Tuberculosis Patient is:

1. To keep him occupied within the physical range of his ailment while ill.
2. To help the physician during the convalescence or arrested stages, in evaluating the potential of his patients physical activities.
3. On the patients return to the community, if Recreation has aided in his Rehabilitation, then the patient will have learned how to provide for his recreational hours without endangering his health.

For Example: Tennis is a very poor game for an arrested TB patient, as it is too strenuous, but golf can be taught to him in slow, easy stages starting with putting and the short game and working up through the years to a strong driving game.

For the Chronic Patient, particularly the one permanently hospitalized, Recreation is his Rehabilitation. He is separated, more or less permanently, from his family and community and only Recreation can compensate for these losses. Recreation must make him feel useful and wanted again. The

chronic patient must develop new interests and new abilities, not only to make him happier, but to make him less of a problem to the staff.

An amazing example of what Recreation can do for the Chronically Ill is the story of Joe, who is a patient at Goldwater Memorial Hospital. He was 30 years of age when he fell out of a window. He broke his spine, was permanently crippled and, then arthritis set in, and he was in constant pain. His family was unable to care for him and then he was sent to a Chronic Hospital. He retired entirely within himself and became non-cooperative and bitter. Before his injury, this patient had held a minor job on a newspaper. After rejecting several copies of the hospital newspaper, he was finally induced to read one. He was not impressed and sent nasty criticisms of the paper to the recreation director through other patients. Then, the Director went to him and suggested that he make his criticisms constructive and help with the make-up of the paper. It took considerable persuading, but Joe finally agreed. Only a year after his first show of interest, he became newspaper editor by a popular vote of the patient staff. Joe's personality has undergone a complete transformation, and he is now a very busy man with his own little office in the hospital, in full charge of all aspects of the newspaper, no more complaining and no more being a problem to the staff.

Another example of a chronic patient's rehabilitation to his surroundings, is that of a 17 year old youth, with Cerebral Palsy, who graduated from the hospital high school with the highest honors. Bernie was often regarded by the uninformed, as practically an idiot because of his many handicaps, but actually his I.Q. was 140. He had to be kept strapped to his stretcher because of constant involuntary movement of his limbs, and suffered too, with a trying and painful slowness of speech. After graduation, he came to the Recreation Director and said, "Now that school is over, what am I to do with the rest of my Life? My mind is as active as anyones, but I'll never be able to leave the hospital. I want to do something creative and live as closely as possible a normal life. If you're a Recreation Director, find the thing I can do to help me pass my life successfully instead of wastefully" This was a terrific challenge, particularly since Bernie's greatest interest was, of all things, the Theatre. He had never in his life attended a theatrical performance, but had read everything pertaining to the theatre he could lay his hands on. After much perplexing thought, the Recreation Director secured the services of a volunteer to take Bernie from ward to ward, soliciting members for a Drama Club: He managed to interest about 25 patients and formed his club. For the last five years, Bernie has been Director of this Chronic Hospital's Drama Club and is so busy with its many affairs, that he has very little time to think of his troubles. His speech has improved so much that he can talk clearly to an audience of 200 in the auditorium; and he has learned to control his muscular movements so well that he now sits up straight, tied in his wheel-chair, instead of lying prone on a stretcher. He is constantly on the search for more suitable plays, and can be heard at any meeting of the Drama Club exhorting its members to new and greater efforts.

Is this NOT true Rehabilitation of the patient to his surroundings?

Now for the N.P. Patient. How can he be rehabilitated if he cannot be brought back into the group society. What better methods are there of getting him to enter into group activities and re-establish contact with his surroundings than his finding self-expression and a possible creative ability

in the activities recreation can offer him? Too—before you can successfully Rehabilitate an N.P. patient, Recreation must aim to develop an interest which will be satisfactory to him spiritually when he is discharged from the hospital. For example: A patient at Franklin Delano Roosevelt Hospital in Montrose had been a musician with a well-known orchestra. His job entailed traveling around the country and his existence was one of the "hustle and bustle" variety. Eventually, the man broke down and was admitted to an institution. Although the Recreation Leader discovered his keen interest in music, it was felt that it would not be advisable for him to resume this activity, since it was related to his breakdown. Therefore, when the Leader discovered that the man was also interested in Photography, he was enrolled immediately in the hospital's Photography Course and proved to be an avid student in this field. He continued some music courses, but photography became his major interest. After his discharge, the man was employed by a photographic firm. Thus, he made photography his vocation and music his avocation.

The N. P. Patient whose condition is chronic, and cannot be returned to the community, can become active in some form of Recreation, and at least keep from deteriorating further. This even if he is merely making feeble attempts at joining in a sports program or perhaps being a member of a percussion band. He is still doing something, not just vegetating!

The Long-Term Patient, differs from the Chronic Patient, in that there is a definite foreseeable limit to the period of his hospitalization. But, while he is in the hospital, he needs a morale builder. His rehabilitation is learning to adjust to his hospital situation and thus, to speed up his recovery.

As for the Child Patient, he has a particular need for happy and healthful play activity when confined by illness or injury. He often suffers an emotional shock when first hospitalized, a feeling of being cut off from his normal world. The problem here is to provide a warmth and understanding to replace loss of the love and security of the child's home environment, and to alleviate his natural fear of the hospital. Games and toys can be as valuable as an added medicine to a child. It is up to Recreation to make it good medicine, and thus, hasten the child's physical rehabilitation.

Now for the Patient Undergoing the Process of Rehabilitation to the community and more likely than not to a job. His Recreation is two-fold. While he is undergoing the strenuous processes of the ADL, he must have something that will relax him when evening comes and help him to refresh from his exhausting day spent with his relearning process. His evenings must also help to counteract the discouragements that he will undergo resulting from the Rehabilitation Processes. Perhaps as important as this is teaching him to re-learn group living and to overcome his self-consciousness due to his handicapped condition. He must learn not to have fear of mixing with people once he leaves the security of the hospital! Recreation can help this patient tremendously by not only teaching him interests adapted to his physical limitation, but while he is in the hospital, help to overcome his self-consciousness by taking him out as often as possible to Recreation Events in the Community. The Recreation Department must see that the patient frequently goes to community activities which he is interested in. Each successive time that they take him to a social event, they must make the traveling conditions less and less protected. (Tell the story of the patient we took to Madison Square Garden and Leon and Eddie's).

In closing, I re-emphasize, if restoring the ill and handicapped to their fullest potential usefulness is Rehabilitation, then, Recreation's part in Rehabilitation is helping these people with limited physical potentials to develop and enjoy as fully as possible the mental and social sides of their life. And, above all, it is up to Recreation to create for the institutionalized some form of community life to help to compensate for his loss of his own community life.

This is my conception of Recreation's part in the Rehabilitation of a patient.

Note—Mrs. Hill then presented a series of colored slides depicting various types of patients and recreation activities designed to rehabilitate. These visual aids were convincing evidence of what recreation really means as a therapeutic factor.

Personality Growth and Development

ALICE MORAN, *Field Director*
American Red Cross, Fort Bragg, North Carolina

Few subjects are more fascinating to us all than "personality." Everybody knows what personality is. Books galore have been written about personality, radio programs, newspapers and magazine articles discuss the subject. One minute tests, revealing all, are made easy for us to give; we need have no excuse for being unable to win friends and influence people, choose a mate with unerring wisdom, sell our goods with neatness and dispatch or turn our own worries and fears into shining assets and lead our friends and our associates out of their particular lands of bondage to Elysian fields, aflow with milk and honey. Truly we should all be personality kids — men and women of glamour, gaiety and glory.

But despite all the books and tests and experts things haven't quite worked out that way. Instead we find ourselves, perhaps as never before, beset by uncertainty, fear anxiety. Those of us who work with people are questioning our methods, techniques and goals. We are appalled by statistics — the numbers of patients in our mental hospitals, the numbers of our young men unfit for military duty, the increase of crime, our highway accidents, outcropping of intolerance, lack of trust in our way of life, unwillingness to make sacrifices, lack of motivation and stamina. Statistics, of course, can prove almost anything and perhaps those of us who work in hospitals, may have too close a view of too many personality casualties. None the less, we have good ground for questioning ourselves about what we are doing, the why and the wherefore of our dealings with people.

We feel that all is not well with our world, our society. Society is made up of people, the inter-relationships of individuals, making the social group, and the social group having tremendous impact on the individual. It sounds like a merry go round. But it does point up the solid fact that it is up to all of us to understand as much as we can about the individual, his growth and his relationship with the life of the world of which he is a part. It is a tenet of our way of life that the social group exists to serve the individual. It behooves us then, who are all in some kind of social work, to acquire all the insight we can get into what makes us tick as individuals.

What is "personality"? The definition is elusive; the word itself overworked. Hence when we use it we may be connating a wide variation of meanings — to each his own. The individual does not "have" personality; he is a "personality." Personality is the sum total of his being; his intellect, his feelings, his physical make up, his awareness of self, and the forces in him of which he is unaware, his way of acting. It is the him who is different from everybody else, because of the uniqueness of his own heritage and his own experiences, since his conception. It is a tremendously complicated entity, the result of infinite numbers of reactions and relationships, all of which are uniquely his own, yet governed by certain basic patterns common to all human organisms.

Our understanding of personality is still far, far from full. Real facts which one may get a grip on hardly exist. Theories and ideas change. The last *fifty years* have seen a tremendous development in our awareness of the complexity of the subject, its value as a subject, and the little we really know about its many facets. Schools of thought differ; today's dicta is tomorrow's fallacy. Our body of knowledge on the subject comes from many fields; the sciences — biology, biochemistry, anthropology, sociology, psychology, psychiatry; history and the law; the arts — drama and fiction, music and the plastic arts through which genius of the past and of the present has opened windows for us that we may gain deeper insight into ourselves and our fellowmen; religion — that deals with our relationship to God and to our fellowmen.

All rather overwhelming isn't it? And how have I ever had the temerity to put myself here to talk to you about "Personality Growth and Development." I believe I gained the courage to do it just because I realize that I am not an expert; however I am a worker with people and that the only way I've been able to do the work has been to formulate for myself, in my own words, what this vast subject means to me. If we stand around waiting until the experts find a nice fool proof formula we'll have quite a stand.

A baby is born — but let us begin even before that — a baby is conceived. At that moment a new personality is created—energized by its own peculiar combinations of potential growth forces from the parental life stream. Protected in the uterus, in the ideal environment for growth, none the less it is highly likely that there are environmental factors already at play which contribute to personality fashioning. The mother's nutrition, emotional state and health may influence the growth through blood stream factors. At any rate, at the time of birth, babies are not all the same — some are placid and quiet, and some are restless and active; their eating, sleeping, waking patterns are varied; their responses to people are different.

Babies are weak and fragile, the most helpless of all new born animals; we accept this as natural. What has always amazed me, however, is how strong they are too. It has always seemed to me important to watch their determination, the force with which they can exert themselves, and their persistence in living, helpless as they are and despite so many adverse happenings. Watching a baby has helped me, feeling the force that is at the root of our being.

I believe that our understanding of the blind force that drives the organism on in accord with its own vital principle, both to keep itself alive and to recreate itself, of the conflicts that ensue as it adapts to the equally

strong force exerted by socializing pressures, gives us a key to the understanding of the growth of the personality.

The baby is a savage who must become socialized or he cannot survive. To achieve mature growth, to reach an adulthood which brings happiness and the acceptance of adult responsibility is the goal of healthy personality growth. This growth is a very complicated process — and depends for its successful achievement primarily on the fact that it is a process going on in a relationship with other human beings.

From his earliest contact with the world outside the womb, the baby finds that living can be painful, frustrating and hostile. He gets cold, wet, and pains in his stomach when he's hungry; lights can hurt his eyes and noises hurt his ears; his skin can hurt when it's chaffed or scratched. But all these perils can be alleviated; he can get dry and warm and feel the security of a warm body next to his own; hungry pains go away; soft lights and gentle sounds replace the harshness; his skin is soothed. He learns very soon that one familiar form, voice, and touch bring all these comforts. He grows and counts on this familiar — his mother. She is always there, and he learns to believe in her, to trust in her because she never fails him. Others come to mean comfort, too; a father, brother or sister, other kindly and comforting figures whose presence bring, relief from boredom, attention and love.

Constantly moving, reaching out, touching, the baby explores his world. Confident that no hurt will come to him because of the presence of benevolent protectors, he can explore and learn that he is something separate from his crib, from other people, that space exists, that his hands can grasp things and draw them nearer, that certain noises mean certain things, as mama and no and good and bad.

But this ideal existence cannot go indefinitely and one day he learns that the all benevolent mother can withhold her smiles and soothing noises, even perhaps look angry and make harsh noises. If Johnny has learned enough trust in his mother though, and he can, if she herself is relaxed and trustful of herself and her love for Johnny, he will not have too much trouble in learning to meet the demands she makes on him to use the toilet, eat at certain times and sleep at certain times, conform increasingly to social living.

As he continues his growth, Johnny has learned that he is loved; he can trust the people he lives with and those whom he feels loves him, and has developed a full knowledge that he is a separate person from Mary. He is important in his own right because he is a member of his family. Now he can walk, talk and adventure. He wants to find out more and more what he can do and he has the courage to go adventuring. He wants to be like father and dreams of being big and strong. Loved despite transgressions; he now finds that he is rewarded for doing things for himself, and he wins praise and esteem because he is a big boy. Certain things he must not do and he has no doubt about it; where he has a choice, his wishes are respected. He is treated as an individual, loved for himself, one of the group with his own value.

He is ready for school and comes now into contact with widening groups. He belongs to his class group as well as his family; secure in his first experiences he can take his place reliantly and go on. His intellectual growth has matured to enable him to learn his lessons; his physical development

permits adjustment to the demands of a wider horizon and his emotional growth permits satisfying friendships with his school fellows.

Adolescence comes along and new factors enter the picture. Johnny's physical growth accelerates; sex tensions increase. The future beckons, attracts, but the well known, the past is comfortable. Where does the adolescent belong? With whom shall he identify himself? It is a vague time with no clear cut path to follow. If, however, the growth process has gone on evenly and Johnny is secure in his past — sure of his value, has sound self esteem, a sense of belonging through his family, school and church, ideals and a sense of moral values, he will survive the period, find himself and be able to go on. He will follow the laws of his inner development and can best be helped by love, encouragement, and a sort of stand-by guidance. As adolescence is survived, he has gained greater confidence, feels more surely his own independence, strength and value and he is now ready to accept the adult responsibility of giving love and accepting the dignity of adult sexuality. Accepting the whole of his life as a total entity he is ready to marry, form his own home and looks forward with strength and dignity to the role of parent and citizen.

Strange as it may seem to some of us, and fortunately for all of us, despite gloomy statistics this over simplified outline is the story of what happens to most of us. But the unfortunate fact is that "most" of us is not enough and it doesn't happen in far too many cases.

As professional workers, interested in people, of what significance is this that we know about how healthy personalities grow? In view of all the gaps in our knowledge, what are we to do when personalities are not healthy? All of us have seen far too many personalities that didn't grow as Johnny's did. We do know, too, that the healthy personality must grow evenly: that it is almost as hopeless to expect a balanced personality to develop if the building has not progressed solidly from foundation to completed whole as it is to build a house by beginning with a roof. Are we helpless, then if in the first years of life things have gone wrong?

Well, from what we know now, it seems we are sometimes. What we, as social welfare workers aim to provide is constructive experience for the people we try to serve. All of us know that there are people whose lack of trust goes down so deeply, whose deprivations have been so severe and so far back that they appear completely beyond our reach. Certainly they cannot be helped by ordinary helping methods — and are a task for the psychiatrist, if even he can succeed. But are we sure that we do not form too ready judgments on some of these people, or give up too easily? Do certain people threaten our own theories, feelings, sense of security? What can we learn from our knowledge of personality growth?

One fact does seem clear: an important element in all of our considerations of personality growth is that our feelings motivate activity. Why does the child develop trust? Because he *feels* about his relationship with his mother. He feels ease, comfort, relief from tension, when she has taken care of him. He feels it in his muscles, his nerves, his bones. He likes to feel free from tension, and when he does, he is happy. He comes to associate happiness with his mother's approach and pain with withdrawal of her protective care. He goes on from there and henceforth, because his mind, his memory makes the connection between relief from tension which is pleasureable, and an action on the part of another human being, his

adaptations are based on his broadening experiences with people, and his relationships to them, which are forever either pleasure giving or painful.

Self esteem is an indispensable component of the health personality. No individual can have self esteem who cannot feel himself as a socially effective person worthy of affection and love, with a definite place in society — all of these things the individual gets through his association with others of his kind who have value in his eyes.

It is evident that, despite the neatness of our outline above, personality is continually open to the impact of the changing scene. At any stage of growth environmental factors may exert retrogressive pressures. Experiences of life, good and bad take effect on the personality. We grow or we regress; we never stand still. Sickness, depressions, wars, death of loved ones, changes in occupation, changes in community and cultural background, come into lives putting stresses on the personality and testing its integrity. But, analyzed isn't it always, the social impact that counts? How does this rate me with those that I love? What will this do to my place in the world? Am I still worthy? Will I continue to be loved?

As we continue, in this world of ours, on our march of progress and we get more and more mechanized — and atomized — as distances shorten, as complex machines are developed, and we have less and less need for the work of man's skilled hands, and working hours shorten, new problems present themselves. What of self esteem to Employee No. 62950? The group can exert malignant pressures, as well as good — discrimination, impersonalization, indifferences. Fear, uncertainty, lack of leadership, conflicting cultures — changing times necessitate the re-evaluation of old goals. How, for instance, interpret courage, today? — no hero on a white charger, buckling on his armour, can sally forth to do combat with an atom bomb. Courage we need, truly, as never before but it is somewhat difficult for Johnny to see Pop as the male super type as he sallies forth in the family Ford to cast his vote on election day. What do we mean by independence today? Is Johnny going to demonstrate his by thundering down the highway in the same Ford at 100 miles an hour? Yet we do know that no one can obtain full personality growth without ideals, standards, the feeling held with conviction that life is purposeful and that there are unselfish goals worth striving for, even to the point of dying for them.

Well we here, as individuals are probably not going to sally forth, either, and save the world—but what can we do to provide "the most constructive experience for the people we try to serve."

We have seen that "feeling" is important — and feeling, let me say again, is *felt*. No amount of "intellectualizing" is going to get anywhere until we "feel" acceptance and get satisfaction out of that feeling. And "serving" people is a two way process. I myself am just as much a part of the process of serving, and play just as vital a role in the relationship as does the recipient of my service. I am a personality, too, and how I feel counts for just as much as how he feels. One challenge, then, is to make it our responsibility to evaluate ourselves. We can see that common sense and intuition are not adequate guides. We, too, are driven by tremendous force — our own needs are strong, our own emotions dynamic. What are our own motivations, what goals do we strive for? What brings us satisfaction and pleasure? We, of course, like everybody else, can never really know ourselves completely but we can be aware that we too are human — really feel it I mean —

and that what we are able to learn about personality is just as true about us as about the other fellow.

When we work with people, we stand in some sort of relationship to them. We represent to them some role—mother or father—people, figures of authority perhaps. Whether we are case workers, group workers, recreation workers, work with individuals or with groups, the people with whom we deal see us as representative of something, as well as, or probably more so, than as ourselves. Most of those we serve have problems of various degrees of severity. It may be no more than minor illness, it may be severe illness. Certainly not every patient has a problem. But every patient has the handicap, that brings him hospitalization, super-imposed on his personality, hence patients are varied as are the variations of personality. Ability to deal with hospitalization well depends on his maturity, in accordance with the severity of the illness. Hospitalization in itself alone imposes a testing, bringing about new environmental influences, unfamiliar routines and ways of life.

Bearing in mind, then that *we* are healthy and that *we* are acting in our own familiar environment, we offer what we have to give. Depending on our own feelings about what we are doing we can make a constructive or destructive experience for the recipient.

We can often see very clearly how a mother hurts her child. When she dominates, smothers, is punitive, over demanding, inconsistent, unloving, we are quite able to say and to see that she is a bad mother whose emotional development has not been sound.

When it comes to ourselves we are less able to see that we simply can't operate with people without having similar components coming in to the picture. If we need to dominate, wield authority, if our own hostile feelings are aroused, disguise it though we may, our giving may do more harm than good. If for instance, a social worker in an agency, in handing out money, goods, all material things, to a person in need but along with the giving, feels it needful to make the victim of her benevolence feel "properly grateful," or blindly conform to certain imposed conditions for receiving that help, it is quite obvious, that the recipient is having his personality hurt, through injury to his already damaged self esteem, if nothing else.

So what? We are personalities, too, and perhaps our patterns are set so that we can't do any thing about them, if indeed we can gain any insight into what we are doing. But lets allay our own anxieties about it all by resorting again to what we know about personality development. No doubt there are people who, through their maladjustments shouldn't be in any kind of social work. It is the responsibility of supervisors, administrators to eliminate them — those that don't eliminate themselves right rapidly because they find small satisfaction themselves in their work For the rest, those reasonably well adjusted people who stay, there is plenty of hope. Attitudes, not facts, count for most. But facts can help us with our attitudes. It is our responsibility to study and to question; to think and to seek out what is known — what research has found, the lessons of history, the wisdom of those who have gone ahead of us.

Beginning with our own realization of the strength and complexity of the forces motivating human behavior and our own oneness with this force we can come to feel with our fellows. We share our frustrations and dis-

appointments, our weaknesses, our own failures and secret sinnings with all who live. Equally real are our dreams and our aspirations, our happinesses and pleasures, the love we feel for our dear ones, the peace that comes through the communion of intimacy, the beauty and order of God's creation and our infinite value as part of that order. As we feel these things ourselves, as we sense our value, and accept our weaknesses, face our responsibilities and experience the satisfactions that come with this maturity, we can come to a realization of the utter dignity and worth of all men, seeking with us the same consumation. It will be no task then, nor imposed discipline, to give our respect, our warmth, our love, to those we serve. Our methods and techniques may differ but we can rest assured that what we do will be constructive and that no man's progress will be impeded by us, who are trying, in however small a way, to serve, under God's fathership, our own and our brother's need.

The Effect of Recreation on the Growth and Development of Personality

BETTY McCONNELL, *Recreation Consultant,*
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(Note: These are summary notes of the general address.)

During the sessions both yesterday and this morning, we have been getting a better understanding of the total field of recreation, of recreation in a medical setting, of the patient himself, and of ourselves as recreation leaders. Now we want to talk about the effect of recreation of the growth and development of personality.

In my opinion, one of the basic objectives of recreation is the opportunity it offers for one to meet personality needs that will enable him to be a happy, participating member of the world in which we live. Because he meets these needs by expressing himself — by living through them in a pleasurable experience — these fulfilled needs then become a part of his personality. However, as Miss Moran has said, personality growth is a dynamic process — capable of change. We have heard or have said ourselves: "He certainly has become a grumpy old man since he has been sick." "Mary has changed. She seems so much happier and more at ease during parties."

What are some of the personality needs that can be met (to some extent at least) by recreation? We know — we have read about them many times — Miss Moran mentioned them this morning. In books, we can find them grouped under four headings or twenty. Sometimes we tend to think of personality as having only one trait "good."

"She has a good personality," or "her personality is not so good." So apparently one's personality is good, not so good, or just not existent. But as professional people, what do we think of as personality needs? They include need to be loved, to belong, to achieve, to be independent, to have new experiences, to be creative, to find dignity and self-esteem, to achieve maturity.

Does every person need some sort of special recreation planned to meet his own personality needs? No. Fortunately many people are able to find, on their own, the kind of recreation that will meet recognized or uncon-

scious personality needs. Under normal circumstances, a person who is lonesome joins a group — a bridge club, Sunday School class, Kiwanis Club, or golf club. If he needs to express himself creatively, he will choose an activity to meet this need. If he needs to be important, that is to achieve recognition, he will probably choose an activity where he can succeed. If he seeks solitude, he will take a walk, play records, work on his stamp collecting hobby.

But not everyone is self-sufficient in meeting his own personality needs by means of participating in recreational activities. Because of many circumstances, a large percentage of people need help in choosing recreation that is "tailor-made" for them.

Thus the recreation leader is needed to provide the opportunity; to help eliminate blocks within the individual which keep him from being able to satisfy his own needs; and to offer him choices that might meet certain temporary needs.

One such group of people is the patient group. A sick person has needs that are unmet, accentuated, or created by his illness. He can not seek satisfactory activity. The confines of the hospital setting and his illness limits his seeking recreation activities of his choice.

In the hospital, the recreation leader is essential. She must first offer a wide variety of activities so that those who are self-sufficient in meeting their personality needs and interest will have an opportunity to participate.

But some patients are unable to participate for various reasons. In such cases the leader must plan purposefully and consciously for individuals having as her main objective to help the patient plan, find and choose his own recreation.

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Next Miss McConnell gave a case history of a patient. This patient had very definite personality needs based in part on his diagnosis, but mostly because of his emotional immaturity and background. Miss McConnell outlined plans the recreation worker had made for the patient based on his personality needs and using his interest in order to help meet them.

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It is the consensus of many recreation workers that the most prevalent need among the patient group is the lack of skills — not knowing how to play. When the opportunities are attractive, when the patients are helped to participate in activities, they become one of the most active groups. It seems that this group relive the play they missed during childhood. . . .

We have found through experience that certain illness groups have common personality needs (whether this is cause or effect is beyond the scope of this discussion.) The diagnosis and treatment of a patient must be considered when planning his recreation. By the same token, let's remember that the patient is an individual. He was a person before he was ill.

We must increase our skills and knowledge so that we can analyze quickly his personality needs — and be content to do only what we can do. In order to do this, we must understand ourselves and our needs. Let's don't lose sight of the fact, or worry about it, that we too are human and sometimes our understanding of someone is blocked.

We have an opportunity to help people but our opportunity lies in our philosophy and in leadership. Only the patient can meet his own personality needs. The doctor can prescribe treatment for the patient's physical con-

dition but only the patient himself will let himself get well by following the treatment; the social worker is there to help the patient with his emotional and personal problems, but only the patient can help himself with these; we as recreational leaders can offer carefully planned recreation for patients to help themselves by participating. Again, our objective is to help the patient become self-sufficient in meeting his own recreational needs through interest in the activities of his choice.

The Meaning and Significance of Illness

PAUL HAUN, M. D., *Assistant Professor of Pyschiatry,*
Bowman Gray School of Medicine, and *Clinical Director,* Graylyn,
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(Excerpts from the address)

In opening his remarks, Dr. Haun quoted from an editorial in the *New England Journal of Medicines* "Only children and philosphers seem interested in why ordinary things are, rather than are not," and suggested that nothing was more ordinary in the hospital setting than illness. He pointed out that illness and disease are defined in the dictionaries in terms of their synonyms or as an impairment of health, while health itself has been narrowly regarded as freedom from disease. The World Health Organization, however, has drawn attention to the positive aspects of health, reminding us that it consists of "complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Modern medical thought still regards the conditions *necessary* for health as the absence of disease, but the conditions sufficient for health involve a state in which the individual can express most of his drives, needs, and urges in socially acceptable form; in which his potentialities are largely realized; in which productivity and individual creation are facilitated and in which happiness and joy are the primary feeling tones.

The semantic problem of understanding the full significance of words used by others, as well as the importance of refining and making exact our own meanings, was stressed. Dr. Haun stated that he would try to discuss both the denotations and connotations of his subject. Illness, he indicated, was not really a synonym for disease. It was a word much used in polite society and as a euphemism. In one setting it may be used as a cloak for social disapproval, as when a butler informs a caller, "I am sorry — the madam is ill (indisposed) and cannot see you"; in another it may refer to a serious, or even fatal, disorder, as in the statement, "He made a will just before his last illness." The word encompasses a wide range of severity, great variation in duration, and quite characteristically involves the subjective feelings of the patient, as in the statement, "The doctor tells me I have severe diabetes, but I don't feel the least bit ill."

Disease, on the other hand, is a more technical word than illness, implies considerable duration, carries an implication of objective, rather than subjective, features, and is never properly employed as a social excuse. Every disease can be thought of as an illness, but not all illnesses as diseases. There has long been a tendency to think of disease as something one "catches" or "gets," like typhoid fever or arteriosclerosis. Medically, a disease is regarded as a short of entity, with definite clinical signs and symptoms; with specific

"causes" (another very difficult word); with a regular course; a reasonably predictable outcome and, at times, definite therapy. Diseases tend to be progressive, usually refer to a process, and are sharply differentiated from accidents and injuries. One never, for example, thinks of the amputee as having the disease of "one-leggedness." Congenital malformations are customarily excluded from the concept, although disease may be both congenital and familial.

It was pointed out that the subject of the Institute—"Hospital Recreation" —set the frame of the discussion; that patients go to hospitals with a complaint, a state, a process, a reaction pattern which troubles them, which stands between them and the condition of health, and from which they seek relief. It was admitted that there is no satisfactory inclusive word to describe these states; that disease was closer to the meaning in some respects than illness but in just as many ways fell short. As a physician, Dr. Haun pointed out that he was more comfortable with the word "disease" and offered as a definition of the statement that disease (illness) was an abnormality of structure or of function which impaired the adjustment of the individual. It was apparent that almost every word of the definition required analysis to make it meaningful.

The abnormal and its converse, the normal, are valuable words which have fallen into recent disrepute because of the difficulty encountered in arriving at their explicit meaning. The tendency to equate normalcy with the statistical average or with the social demands of a particular culture was noted and the question raised as to whether an individual who did not have convulsive seizures would be considered abnormal in an epileptic colony; a myopic individual normal in a society of the short-sighted. Attention was called to the impossibility of transposing a statistical average between cultures; for example, the relative susceptibility to smallpox, meningococcic meningitis, or tuberculosis in New York City and in Papua. How can one arrive at the normal in comparing the height and weight of the Japanese and Californian adolescent. The size of the sample, the cultural standards of the community, the historical era, the racial experience, and the vast and interlocking sequence of environmental, constitutional, and hereditary elements must be assessed in all such considerations.

In spite of the recognized complexity of the task, a tentative statement was offered that the normal *is* the statistical average when two additional conditions are obtained: (1) All biologic potentialities of the specie are being realized; (2) The total impact of the environmental influences favors perpetuation of the race. An abnormality, then, would be of a deviation from the statistical average which impedes or prevents realization of the biologic potentialities of the specie and which adversely influences the continuity of the race.

Turning to the next word in his definition, Dr. Haun stated that to the medical worker, "structure" was generally felt to be safe and familiar territory, being the area in which the doctor traditionally operates. It tended to involve such clear-cut organic pathology as cirrhosis of the liver, valvular heart disease, hemorrhage of the brain, and cancer of the bowel. Dealing with essentially objective manifestations which could be directly seen, examined, touched, and compared either on the autopsy table or during life, the field of structure has been historically comfortable, forming the basis for many of our past beliefs that diseases were things one "got" or "caught." Such

endogenous processes as peptic ulcer, which occupy the interesting transitional zone between "getting" and "being," and the disease of epilepsy, which may occur *without* structural pathology, introduced a serious rift in the orderly assumption that diseases were always manifestations of organic pathology.

The concept of *function* clarifies many of these problems when it is realized that isolated parts of the body or the sum of all the organs may not *behave* in a "normal" fashion, even though organic pathology is entirely absent. Such disorders as asthma, angina pectoris, speech, reading, and writing difficulties, eclampsia, and, of course, a vast range of psychiatric disturbances all may occur without aberration in structure. All are, however, manifestations of serious disturbances in function. This is the point at which the so-called medical realist experiences difficulty. A grasp of the facts as they are now widely understood entails the conceptualization of a continuing series from organic through psychosomatic to functional disturbances, without the presence of identifiable lines of demarcation. Such a viewpoint considers a search for the bacillus of grief as pointless as the view that objective organic pathology is hallucinatory. Denial of the significance of function in clinical practice involved the medical worker in the unenviable position of denying the possibility of falling in love, the existence of jealousy or of hate. Man must, of course, be identified as a physical organism but he is nonetheless, nor any less importantly, a thinking, a feeling, and a believing organism. Contemporary medical thought regards him primarily as a unitary organism acting and reacting in a social context.

The word "impair" was chosen in the definition of disease because it is relative and can include the mild, the moderate, and the severe.

Adjustment, perhaps the most significant word of the definition, includes three essential concepts:

(a) Homeostasis, the balanced physiologic equilibrium between organs and systems of the body.

(b) The psychic state, or the character. In this sense, adjustment is concerned with such things as peace of mind, inner security, self-respect, and maturity.

(c) Environmental relationships in all their complexity; rélationships to things, to natural and cultural forces, and to people. It includes one's social, political, religious, economic, and familial relationships, to name but a few.

Adjustment obviously may be faulty in one or all of these areas and any degree of impairment may be noted. Dr. Haun quoted from Karl Menninger's "Changing Concepts of Disease," an address delivered before the 29th Annual Meeting of the American College of Physicians and published in the *Annals of Internal Medicine* for August, 1948. He concluded his remarks by stating that the definition of disease which had been offered left much to be desired: "Perhaps we will never come to an Aristotelian definition of disease or, for that matter, of life or of energy. It is worth our notice, however, that a very ancient profession—that of the physician—has devoted itself for centuries to one end: the diagnosis, treatment, and prevention of disease. As research continues and as medical thinking probes deeper and deeper into the mysteries of the unknown, we are assured that the boundaries of disease will grow more and more clear and that unremitting attention will continue to be paid to the very topic we have lightly touched today—the meaning and significance of illness."

The Effect of Illness on the Individual

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(Excerpts from the address)

Considering maturity as characterized by a good capacity for successful adaptation, we might begin by suggesting that maturity and health are closely related but not identical concepts. That is, the healthy person is also a mature person; but on the other hand a mature person may, under sufficiently severe stress, decompensate, in which case he becomes ill. *Health, then, implies being in and maintaining a state of successful adaptation.* This involves a condition of internal harmony or balance, a steady state, which can be maintained with a minimum expenditure of energy, and in which energy is available for the life tasks.

In contrast to this we offer the suggestion that disease represents a state of unbalance, or disharmony, where the organism has failed in its adaptation to stress.

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When the organism is successfully adapted to its environment and is able to maintain this state free of undue excitation and relatively free to pursue life's tasks, a state of health is said to exist. On the other hand, when adaptation fails, when the dynamic equilibrium with the environment is disrupted, a state of disease may be said to exist until an effective equilibrium can again be achieved and effective interaction with the environment restored. Both health and disease must be necessity to relative terms, and a sharp dividing line is not always possible. One may speak of a person as being more or less healthy. The presence of disease may be established on both subjective and objective grounds.

The task of medical science then, is to develop means of interpreting the symptoms which patients bring and of evaluating and discovering objective signs of adaptive failures, and to develop techniques of aiding the adaptive process. The magnitude of this job is such as to necessitate specialization of interest and technique (isolation), but it is important to retain an overall perspective of the whole problem of adaptation. Each of the medical disciplines, preclinical and clinical, deals with the same basic problem of adaptation, successful and unsuccessful, and each focuses on some particular aspect or system. Dynamic psychology and psychiatry, because they are concerned with the integrative systems, the overall adaptation of the organism to internal and environmental forces, have concern with all the branches of medicine and further, stand between the natural sciences and the social sciences. Therefore, there is no disease with which we are not concerned.

The human organism, in common with other living structures, must in relationship to its environment maintain its *intactness, grow*, and *reproduce* (the instinctual drives) and in pursuing this destiny it encounters and must overcome a great variety of stresses. A continuous struggle ensues between the organism and the environment. If the organism succeeds in maintaining mastery of the environment, health is the result; if success is incomplete, disease is the outcome; and if the environment wins, death results.

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In dealing with the environment and in pursuing its instinctual aims the organism operates as an integrated unit and all bodily functions are attuned

to the task of avoiding too strong excitation, from within or without, and maintaining a state free of uncomfortable pressures. But when the individual encounters an environmental force which acts to disrupt directly the physiological integration (i.e., a pathogenic bacteria or physical trauma) or to block the gratification of an instinctual need (i.e., a nutritional deprivation or a sexual taboo), some attempt at adaptation to this situation must be made. The speed and effectiveness of this adaptation will determine whether or not health is retained or disease results.

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All levels of adaptation are concerned—chemical, physiological, psychological and social. For this discussion we will focus our attention chiefly on the adaptive mechanisms of the mental apparatus, keeping in mind that all expressions and responses of the mental apparatus are accomplished by the body and its various organ systems.

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Disease may be brought about in a number of ways:

1. A developmental or acquired defect or constitutional weakness of some organ or part of the body which interferes with certain adaptive functions from birth on. Theoretically this may include defects in the mental apparatus itself and of course in the brain, the organ of the ego.

2. An outer stress, which interferes seriously with basic needs or which damages parts or systems of the body. This might include such things as inadequate water, food and oxygen as well as love; physical trauma, parasites, poisons, etc., as well as a threat of these (i.e., physical trauma from anger).

3. A change in internal dynamics which require a changed relationship to the environment, such as for example, occurs at puberty, pregnancy, menopause, etc. Such a change may also be stimulated by an external stimulus which mobilizes latent internal forces (i.e., a sexual temptation or an allergy).

4. Any combination of the first three may be implicated.

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No static concept of stress can be entertained. What constitutes a stress at one phase or period of life or under one circumstance, may be quite innocuous or easily dealt with at other times. As examples one might cite the effect of smallpox virus before and after vaccination (i.e., before and after a new adaptation) or the effect of separation from a parent at age one and 31. Whether or not such situations continue to be stressful depends upon what adaptations have taken place. Therefore in evaluating a possible stress, it is necessary to know something of its intensity, duration, acuteness, as well as the previous experience of the individual with the possible stress.

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When a stress is encountered the organism must deal with it, regardless of its source. If the capacity of the organism to deal with the stress is not high, disease (or death) is the result. The symptoms (subjective manifestations) and signs (objective manifestations) of disease will thus consist of a combination of the following:

1. The instinctual need seeking or requiring satisfaction (i.e., the sugar appetite of the diabetic, the call for help of the person with pain, or the disguised aggression of the person whose direct expression of aggression is blocked).

2. The inner perception of a disturbed equilibrium or an unsatisfied need. This introduces the concept of conscious and unconscious anxiety and guilt as well as the general awareness expressed as "I'm sick," "I feel badly," etc.

3. The various adaptive devices, old and new, chemical and physiological, psychological, and social which come into play to cope with the stress and to restore equilibrium.

4. The actual structural or functional damage which results from the stress itself (i.e., fractured leg or cavitation of lungs from tuberculosis) or from failures of adaptation.

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In any patient the total picture of the illness can be comprehended and understood if these four contributors to the clinical picture are kept in mind.

Implicit in this concept of disease is the idea that there is some internal perception or awareness of disturbed equilibrium or unsatisfied need which somehow triggers the adaptive response. Such a concept might be illustrated through *anxiety* which is defined as: "The danger signal by the ego indicating that the balance is in danger of being upset by an access of too strong instinctual forces or intolerable external forces that threaten the integrity of the organism and might not be mastered."

Anxiety may be thought of as a danger signal, a warning to the organism that it might be destroyed or damaged. The basic condition for the development of anxiety is that in which the organism is overwhelmed by an excess of excitation, originating internally or externally. This includes the birth process itself, hunger, sucking need, thirst, suffocation, physical restraint, loud noise, bright light, large objects, painful stimulation, etc. Such stresses are mastered to varying degrees, but the tolerable thresholds may be exceeded in later life, leading to recurrence of anxiety and the necessity for new adaptations to reduce the intensity of the stimulation. This may be illustrated by the anxiety which might be provoked by a loud noise, a flash of light, or a sudden intense bodily sensation.

Since protection from such excessive stimulation is provided the dependent, helpless infant by the parent, separation from the parent may in itself be felt as a danger, particularly if separation and intolerable excitation are associated in a cause and effect relation. Thus when the parent is not visible, audible, or reachable by a cry, the infant may feel in danger of overwhelming excitation. This accounts for the fear of darkness, strangers, being alone, etc. which characterizes many small children. Any illness at any age may revive such fears. This is the anxiety of the period of dependency.

* * * *

Thereafter, one may visualize the danger signal of anxiety arising whenever the child has to deal with internal pressures which cannot be satisfied or which bring him into conflict with his environment and when he encounters excessive stress or stimulation from his environment. When the anxiety of the child is successful in fulfilling its function as a danger signal and leads to the mobilization of appropriate and adequate adaptations a healthy development results. Where failures or poor or no adaptations occur these are left behind as weak spots or chinks in the defensive armor.

* * * *

While many other aspects of this subject may be presented, this general analysis will suffice to indicate the place of the effects of illness on the in-

dividual. This and other knowledge related to the problem can prove of value to the hospital recreation leader in cooperation with the doctor and hospital administration in bringing maximum services to the patient.

Leadership

By Marion Preece,
Field Representative, Southern District, National Recreation Association

(Excerpts from the address)

As one studies the hospital recreation field, there is immediate concern and interest in leadership. It is this way in all divisions of recreation—leadership is the outstanding problem. The effectiveness of any program depends upon the type of leaders directing the program.

Within the past few years a number of interesting developments have occurred in regard to better personnel:

1. The universities and colleges of the country are becoming increasingly aware of recreation and are developing a curriculum designed to produce good leaders.
2. The universities and colleges are also sponsoring correspondence courses and extension classes to assist in the improvement of leaders now in the field.
3. Recreation workers on the administrative level are putting stress on in-service training, thus constantly enriching personnel.
4. Attention is being given to research on this subject and texts and manuscripts are being published in increasing numbers.
5. Gradually young people are realizing that recreation is a field of career opportunity, and more and more of them are going into recreation leadership studies.
6. The National Recreation Association has a strong Committee on Personnel broken down into various sub-divisions giving concentrated attention to the promotion of leadership.

It is interesting to note the progress made by hospital recreation personnel over the past years in the understanding of the job to be done and the techniques developed. Through the programs of the Veterans Administration, the American National Red Cross, and the work in the various state institutions, along with the interest in general hospitals, public and private, there is rapidly developing throughout the country a strong recreation leadership in the hospital field. To the full-time and part-time professional leaders must be added a vast army of volunteers.

If we are to realize the potentialities of recreation for developing desirable character traits, encouraging skills, and awakening life-time interests, we must recognize the need for highly qualified leaders.

Due to the variety of leisure time activities the standards desired and the methods involved in programs it is essential that leaders be given a broad educational background as well as training in the special area of the recreation field which they are preparing for. Emphasis must be placed on the philosophy of recreation as well as on the techniques required for implementing the program. Pre-service training and internship should be generally comparable in amount and thoroughness to that preparation required for any professional service.

Needless to say the training process should continue while leaders are on the job.

Recreation must compete with other fields of employment in attracting and holding qualified workers. Those familiar with the current practice in recreation will notice the discrepancy between actual conditions in the field and theoretical standards. This will be apparent most strikingly in respect to recommended standards of education and the actual compensations such as salary, recognition, retirement, vacations, and other general practices relating to recreation employment. In order to secure and retain the right kind of personnel, conditions of employment attractive to qualified workers and compensations commensurate with preparation must be provided as well as opportunity for the leader to achieve satisfaction and status for a job well done.

How Can Recreation Needs be Discovered and Met?

Group Discussions: Leader, Madolin Cannon, *Recreation Consultant,*
Eastern Area Office, American Red Cross, Alexandria, Virginia.

In the previous sessions we have reviewed *the philosophy of recreation* which recognizes the basic needs of individuals, the effect of illness on the individual, and the effect of recreation on personality growth and development. With this background and knowledge, we will try during this session to see how the recreation leader can discover the recreation needs of patients and how these needs can be met.

We are often remiss as recreation leaders in properly interpreting to others, and even to ourselves, the necessary purposeful planning of our work with people. We are prone to give a superficial response to inquiries about the service which we are providing. Some of us may have intuitive ability to evaluate situations and we neglect to analyze the factors that were important in meeting the situation successfully. We are apt to be deeply offended when we are not afforded the professional recognition which we believe is our due. We allow others to believe that our work is just a lark and that all that is needed to be a successful recreation leader is an outgoing personality, an interest in people and an ability to get along with all types of personalities. When we are asked about our work, we usually rattle off a list of activities, all of which sound like fun and we let the matter drop at that point.

How many of us take the time to explain the considerations which we have to give for each recreation service in terms of:

Knowledge of the individuals concerned, their interests, background, abilities, limitations and personality traits.

The physical facilities and equipment available.

Medical information on the various illnesses and disabilities in our hospital.

Knowledge of the strengths and weaknesses of the available leaders in professional, volunteer and patient categories.

And, the skill of co-ordinating all these factors together to provide a worthwhile service to our patients.

Let us this afternoon try to analyze the methods which we use to find the interests of our patients and also to consider the factors involved in meeting these discovered recreation needs. There are some areas of recreation service

such as movies, spectator type shows and dances which fall into more or less of a pattern because of the general interest of groups of patients. Let us not concern ourselves with this fact of group recreation service but concentrate on the recreation service which is geared to and focused on the interests and abilities of the individual patients.

To facilitate covering the subject in the allotted time and to take the opportunity of pooling our thoughts, we decided that we would use a little student participation in terms of so called Buzz groups. Half of the groups will focus on methods of discovering recreation needs while the other group will concentrate on the factors involved in meeting these needs. Each group will discuss one aspect. One member of each group will act as the leader to guide the discussion and keep it on the question concerned. There will also be a reporter in each group who will note the major points brought out by the group and who will report the findings to the total body at the close of the discussion period. The discussion period will be twenty minutes in length. The responsibility of each group member will be to contribute to the discussion of the questions at hand, to recognize that each person in the group is an important entity and to gear his thinking to an objective discussion of the subject at hand. The leader and reporter in each group will make themselves known to you. They have had a brief training on their particular function. The groups were then formed and had a discussion period. Each chairman then presented an outline of the finding upon which general discussion followed.

GROUP SESSIONS

GROUP I. How does the recreation worker in her relationship with the individual patient pick up clues of patient's interests?

Establishment of rapport between recreation.

Visiting each new patient.

Ward survey to find special interests.

Publicity through the medium of a bulletin board or patient publication.

Suggestion box.

Close observation of patient during activity, noting response, strengths and weaknesses.

Patient Council.

GROUP II. How far does the recreation worker's responsibility go in determining recreation service within medical limitations?

Workers must have general information on the type background and limitations of the illness.

Worker must know specific limitations of special disabilities such as T.B.

Worker must consult with doctor to determine limitations as they relate to recreation.

Worker has responsibility to interpret situation and adaptations of recreation service to the medical staff.

Regular medical approval must be obtained by worker for the program.

GROUP III. What background information is important for recreation leader to know about individual patients?

Age of patient.

Educational background.

Former occupation.

Cultural background.

Patient's talents and skills.

GROUP IV. What other personnel should the recreation worker use as resources for discovering the recreation interests of individual patients?

All contacts with patient on a professional, non-professional, social, medical, and personnel basis such as:

Doctors, nurses, attendants.

Social workers, chaplains, librarians, O.T., P.T.

Volunteers, including community groups.

Other patients.

Patient's relatives.

Recreation worker should educate the above to observe, be aware, and to secure information regarding the interests and needs of patients.

GROUP V. When medical limitations restrict the patient from pursuing previous interests, how does the recreation worker adapt recreation service?

Begin with adaptations of present interests.

Adaptations of equipment.

Think in terms of interests rather than activity such as forums, discussion groups, hobby interests.

Redirection may be accomplished by exposure to interests of others.

GROUP VI. When the physical space and equipment are limited, what adaptations can be made?

Through ingenuity of recreation worker, hall activities can be adapted to ward situations if pre-planning is given to adaptation of equipment and space.

A pre-planning can be utilized if the presentation space is inadequate.

GROUP VII. What constitutes minimum space and equipment for recreation service in a hospital setting?

Minimum equipment—music, piano, record player, radio

Movies

Games—table games, cards, etc.

Minimum space—storage space for equipment.

recreation office

space to work with patients on wards or recreation room.

GROUP VIII. What are sources for leadership assistance which should be used by recreation workers in meeting the recreation needs of patients?

Recreation leader herself plus professional recreation staff.

Patients, individual and council members.

Hospital staff, such as ward attendants and other professional hospital staff who have special skills.

Volunteers—individuals and community groups, including hobbyists.

The Volunteer in Hospital Recreation

C. C. Bream, Jr., *Chief,* Recreation Division, Recreation Service, Special Services, Veterans Administration—Washington, D. C.

Few, if any hospitals represented here today or throughout the United States, are sufficiently staffed with professional recreation personnel to meet fully and completely the medically approved recreation needs of their patients. Of the several ways to remedy a situation of this nature, one of the surestand best means is through the wise and intelligent use of volunteers. This does not mean that you would be getting something for nothing. Such

a misconception on the part of management, and, in this case, the Recreation staff, can lead to unfortunate consequences. If the contribution of volunteers to the hospital program is to be truly meaningful and worthwhile, there is a cost involved to both management and the recreation staff in the outlay of time, energy, planning, devising, adapting, supervising, evaluating, and on-the-job instruction.

The wise and intelligent use of volunteers in any hospital program requires hard work on the part of the "user." The degree of efficiency and value of the contribution of the volunteer to the recreation program is dependent to a great extent on the planning of the concerned professional Recreation personnel that preceded the services rendered by the volunteers. The value of the contribution of the volunteer to the recreation program depends as much upon the method and manner of handling the volunteer by concerned hospital personnel as it does upon the caliber of the volunteer himself.

To do an effective job and, thereby, make a real contribution to the hospital recreation program, the volunteer must experience continually a rich, creative, and satisfying feeling of being of real service to others who need help. The person in charge of the hospital recreation program (Recreation Director; Chief, Recreation Section) is responsible for obtaining and maintaining this condition. (For purposes of this paper the person responsible to management for the conduct and operation of the hospital recreation program will be referred to as the "Recreation Director.")

Effective utilization of volunteers is one of the major responsibilities of the Recreation Director. The following steps are recommended in discharging this responsibility:

1. *Determine the Need for Volunteers*

a. *Determine the scope of the recreation program for your hospital*—its depth and breadth. This will require an intimate knowledge of the specific and general abilities of each member of your professional Recreation staff, the facilities and equipment with which to work including those of the community that will be available, and the number and types of patients being treated. From this information you will be able to plan the basic program for your hospital.

b. *Consult with management and responsible medical personnel* for the purpose of recommending the program you believe will prove most beneficial to the patient, and thus be of greatest assistance to the doctor in his work of helping the patient get well. From such a conference or conferences your basic program will be determined. This is not to imply that there will not be changes in the program from time to time. No recreation program worthy of its position in a treatment program can afford to remain set and static. The Recreation Director is then required to determine the number of volunteers that will be needed to supplement the work of his professional staff in conducting the medically desired and approved program for his hospital.

2. *Recruitment of Volunteers.* Having determined the number of volunteers that will be needed in the hospital recreation program, the next major step is recruitment of volunteers. Recent experience gained in the activation of new hospitals has proved the wisdom of starting with fewer volunteers than is believed will be ultimately needed. In so doing, you will be rendering a service to the volunteers who are selected, and enhance the chances of your recreation program proving more acceptable to management, medics, and patients. All too often volunteers are recruited quantitatively rather than

qualitatively, resulting in more volunteers being accepted than can be properly supervised. Being overstaffed with professional Recreation personnel can be more harmful to a recreation program than being understaffed. In like manner, a recreation program can be irreparably harmed by having more volunteers than can be efficiently and effectively used.

Recruitment of volunteers must be accomplished in a systematic manner. This is as necessary for the the small, private or community hospital as it is for the larger state or federal hospital.

A "clearing station" through which volunteers are recruited will be of inestimable value to the Recreation Director. Through such a station the specific needs of the hospital, for volunteers, can be made known to organizations, or, in some cases, specific individuals having the qualifications, background, and experience required. The size and makeup of these "clearing stations" vary greatly. In some small hospitals where the need for volunteers is limited, the Recreation Director alone serves in such a capacity, making direct contact with community service clubs, national organizations, and individuals, in order to obtain the volunteers desired. Other Recreation Directors of small hospitals, with the consent and cooperation of the hospital management, benefit in recruiting volunteers through the use of an established Hospital Recreation Volunteer Committee of the community. Such a committee receives from the Recreation Director requests for volunteer assistance and, in turn, carries out the functions necessary to obtain volunteers with the qualifications required for the job to be done. The agency with which I am privileged to be associated, namely, the Veterans Administration, has a very definite and clearly outlined procedure of recruitment. The expressed needs of the chief recreation section are made known to the hospital volunteer committee composed of representatives of both local and national service and welfare organizations. Through the membership of these organizations, individuals or groups are recruited for possible assignment in the hospital recreation program.

For those of you not connected with the Veterans Administration, I want to assure you that there are definite regulations and established procedures which are followed in the recruitment and utilization of volunteers in the Veterans Administration recreation program. For your information, the Veterans Administration program, which is known as the Veterans Administration Voluntary Service program, is clearly outlined in VA Pamphlet 6-2, entitled "Your Job as a Volunteer."

3. *Screening and Selecting the Volunteer.* The details involved in this step are of such a nature and of such magnitude that the responsibilities involved must be shared with the organizations providing the volunteers or other persons capable of rendering such assistance. The importance of screening volunteers previous to selection for the work to be done cannot be overestimated. Then, too, the volunteer's ability to perform the specific tasks to which he may be assigned must be determined as well as possible in advance. The best means for making such determination concerning the prospective volunteer are:

a. Interview

b. Observing under simulated conditions.

c. Review of such personal records as may be made available.

d. Reference from individuals and organizations with whom he has worked or been associated.

The following criteria have been used successfully in determining the suitability of a volunteer engaging in hospital recreation, involving as it does contact with sick people:

1. Emotional stability—stability on the job.
2. Sense of personal responsibility.
3. Honesty and integrity.
4. Neatness and presentability.
5. Ease in working with others.
6. Earnest desire to serve sick people.
7. Physical ability to perform the assignment.
8. Personality traits, such as tact, patience, congeniality, and kindness.
9. Sense of pride in volunteer work.

During this period of screening it should be possible to learn something of the volunteer's talents and abilities in specific fields; personal interests and hobbies, as well as experience and training background. Such information will be helpful in the assignment of the volunteer to a particular field or a specific job in the recreation program.

In addition, the prospective volunteer should be apprised of the hospital's:

1. History.
2. Standards.
3. Source of income.
4. Type and number of patients.
5. Organizational operations structure.
6. Personnel practices and governing statutes.
7. Volunteer services being rendered, and by whom.

Assuming the volunteer has successfully passed the standards established for assignment and there is a need for his assistance in a particular field or for a specific job in the recreation program, the Recreation Director or his designated representatives should then discuss, in detail, the specific responsibilities involved when serving in the recreation program. This should include a candid discussion of the requirements for the job, the functions, purposes, and exact nature of the prospective assignment. During the interview the job must be defined, basic regulations governing the conduct of activities understood, and general operation of the recreation program and the management of the hospital clearly explained. This would include the number of hours per day, week, or month that will be required of the volunteer, the initial preparation necessary to fulfill the assignment, and the limitations, if any, of the job to be done. At the completion of this interview the volunteer should have a clear picture and a complete understanding of the assignment and all the ramifications involved.

Activities of the hospital recreation program, in which volunteers may render assistance, include:

1. Supplementary leadership which may include instruction in hobby clubs, music, dramatics, sports, dancing, discussion groups, group reading, arts and crafts, and the like.

2. Supplemental clerical assistance; conducting polls and surveys to determine patient preferences for recreation activities.

3. Projecting 16mm. movies.

4. Assistance in developing and conducting contests, exhibitions, and carnivals.

5. Assistance in publishing the hospital newspaper.
6. Operation of radio system.
7. Lounge supervisor.

If the volunteer is still interested in hospital recreation and is believed capable of making a contribution, he begins a probationary period of carrying out the assignment for which selected.

Of utmost importance at this point is putting the volunteer at ease and making him feel his presence is desired and important. He should be taken on a tour of the principal parts of the hospital and introduced to all personnel with whom he will associate in his work. Where will his "headquarters" be located; where does he "hang his hat"; when and to whom does he report; what, if any, advance preparation is necessary? These are a few details, seemingly minor in nature but of great importance to the volunteer in his initial visits to, and his participation in the work to be done at, the hospital.

Another practical and valuable aid to be made available to the volunteer is a list of basic "Do's and Don'ts for Volunteer Workers in Hospital Recreation." These "Do's and Don'ts" should be briefly stated and easily understood. They should cover such items concerning the volunteer as conduct and decorum, dress, and conversation hints. Workshops for volunteers have also proved very valuable during this probationary period. Through this method the volunteer is afforded an opportunity to experience a working situation and, at the same time, the Recreation Director is able to appraise further the volunteer's qualities and abilities.

At the completion of his probationary period the final determination is made between the Recreation Director and the volunteer as to whether or not the volunteer will continue as a member of the recreation "team." Frankness and honesty have proved to be the very best policy to be followed by both parties in making this final decision.

Assigning the volunteer properly and supervising his work adequately after he has been accepted as a member of the team will contribute immeasurably to the enthusiasm and interest of the volunteer for his work, and to the overall effectiveness of the recreation program. Determining the right job for the right volunteer can only be accomplished through thorough study and evaluation of the information at hand concerning the volunteer. Data are assembled from the information gained during the screening and interview, from references received, and from personal observation of the volunteer during the probationary period. From this fund of information the Recreation Director, or his designate, will make such assignment as, in his opinion, will be most interesting to the volunteer and, at the same time, most beneficial to the program. Volunteer assistance will be most effective and will make a maximum contribution to the program when given meaningful and purposeful guidance. This requires training or on-the-job instruction of the volunteer. Such instruction will vary in duration, scope, and intensity. Some instruction will include courses of weeks or months plus practice in doing the job at hand, while other jobs-at-hand will require instruction that can be mastered in a few hours or days. Experience has proved that volunteers will do their best work when the following conditions obtain:

1. When they feel there is a genuine need for the work they are asked to do.

2. When the assigned tasks are adjusted to their abilities, are definite, and are in writing.

3. When their associates are sociable and congenial.

4. When they see the relationship of their task to the objectives and functions of the total service.

5. When reasonable attention is paid to the proper maintenance of the places in which they are asked to work.

6. When they are not kept waiting too long for assignments.

7. When they are not begrudged the time required to train and supervise them.

8. When recognition is given for services rendered.

9. When opportunity is given them for initiative and creative activity.

10. When they are held to a definite responsibility.

This will be possible when adequate supervision is afforded by the professional Recreation staff.

And supervision is just as essential for the volunteer whose technical and professional qualifications for the specific job may be—as they often are—higher than those of the Recreation staff. It must be borne in mind, however, that the setting in which volunteers in hospital recreation are working is vastly different from the setting for the normal accomplishment of their daily operations. Supervision for the highly qualified volunteer, though a highly respected individual in his own field, can be more important than for the volunteer less highly qualified. Very few volunteers will not want to be properly supervised, particularly during their neophyte days at the hospital.

What is this supervision we talk about? What is its purpose? How is it accomplished? What are the desired results?

The major purpose of volunteer supervision is to improve the effectiveness of the contribution being made through maximum development of the potential contribution of the volunteer.

Supervision cannot be a cut-and-dried procedure — it must be flexible. What will prove to be good supervision for one volunteer or group of volunteers might be most inadequate for another. The volunteer should be responsible to ONE PERSON only and that person must be, 1) an employee of the hospital, and 2) should be in all but a very few instances a professional Recreation staff member. Supervision of the volunteer should be a program of cooperative leadership development. This can be accomplished through personal observation in which the following practical consideration must be recognized:

1. Is the assignment proper?

2. Are the objectives of the immediate project and the program generally being met?

3. Restatement of what is expected.

4. Favorable climate for free, frank, and open discussion in individual conferences and staff meetings.

5. Successful accomplishments.

(Candidly show weaknesses, solicit suggestions, approve experiments — as feasible).

It is well to remember that quite often the contribution of a volunteer to a hospital is not confined to carrying out the specific task of his assignment. Many innovations in hospital recreation today can be traced to

the stimulating suggestions of volunteers. The potential value inherent in his ability to interpret the mission of the hospital and the problems involved in serving the community must not be overlooked or underestimated.

The chief function of leadership is to draw out, strengthen, and put into action any desirable leadership capacities that may be present in an individual or group.

A most effective tool of supervision is evaluation. The entire process of supervising the daily performance of the volunteer is a continuous process of evaluation. Evaluation has for its major purpose program enrichment and future program planning, in addition to serving as a measure of growth for the volunteer. The value of the volunteer's contribution to the patient and to the program can best be determined by a thorough system of evaluation. At this time misunderstandings and misinterpretations can be discovered and corrected. New and better approaches, methods, and techniques can be developed which will result in a more valuable contribution by the volunteer and a meaningful professional recreation program.

While basically the evaluation will be made by the responsible recreation employee and the individual volunteer or volunteers, complete evaluation may encompass every individual reached or concerned with the program. In this connection, never lose sight of the fact that the patient himself can, in many cases, make the more valuable contribution to evaluation.

There are intangible, but very real compensations for volunteer service which are in direct proportion to the sincerity of spirit with which service is rendered. There is the keen personal satisfaction of doing a job well; of being of service to others who need help; of being an active and appreciated worker in the highest type of community project, the health agency.

"Such experience leads to a better understanding of human nature; a keener appreciation of the need for better human relationships everywhere.

"Volunteer service is a fine and gracious expression of the spirit of citizen participation which is the very breath of life to our American democracy.[1]

However, to those contributing valuable assistance, timely and appropriate recognition of their efforts should be made. This means of compensating the volunteer may be:

1. Personal compliment, publicly.
2. Describe the work accomplished and its results — naming the individual or the group.
3. Inform one in higher authority at the hospital (Chief, Professional Services or Manager), and tell the volunteer you have done so.
4. Personal letter of commendation.
5. Personal Certificate of Merit or Commendation.

Such forms of recognition may be made even more impressive and meaningful if presented with appropriate ceremony when feasible and practical.

"The volunteer worker and the paid worker become an effective team when each recognizes and respects the defined responsibilities and particular capacities of the other."[2]

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[1] *Welfare Council of Metropolitan Los Angeles.*

[2] *Principles of Volunteer Service,* published by the Community Chests and Councils of America.

Hospital Administration Looks at Recreation

James W. Murdock, *Superintendent*
State Hospital, Butner, North Carolina

(Note: Excerpt from address)

The speaker stressed that where there is no recreation program the expenditures on maintenance in a mental hospital and on sedative drugs are high; and gave several examples within his own experience. An extensive and intelligently used recreation program will eliminate much of this expenditure.

The speaker also stressed the fact that as long as a patient remained in the hospital, the community was not receiving any benefit from his productive powers. Recreation serves the purpose of resocializing the patient (and the mental patient is one of the loneliest and least social persons in the world because his delusions and hallucinations cannot be experienced by others), so that he may become able to resume his place in family life, in community affairs, and in economic life. One must regard recreation as a positive therapy and not as a pleasant escape for tedium. Recreation must be employed with all other forms of therapy as early as is practicable and prolonged until benefit is gained. No hospital can be complete without a recreation program.

Swap Fest

Edgar W. Johnson, *Chief Therapist,* Department of Physical Medicine
Graylyn Hospital, Winston-Salem, North Carolina

Program ideas were exchanged by those attending this session. They were discussed under the following divisions:

A. General Classification of Patients:

1. Balloon parties. Very colorful events in which balloons may be used in relays, including:
   a. Sweeping
   b. Batting in the air
   c. Kicking
   d. Butting with the head

A part of the evening may be spent in dancing, with balloons tied to the ankles. An attempt is made by the dancers to break other couples' balloons.

2. Newspaper parties. Group may be divided into want ad, for sale, sports, and editorial sections.
   a. A newspaper is written about amusing incidents which have happened during the patients' recent hospitalization.
   b. Each group tries to dress one of its members in the most unique fashion, using only newspapers and something appropriate (pins, Scotch tape, or paste) to hold them on.
3. Sight-seeing trips to nearby points of interest.

B. Markedly Disturbed Neuropsychiatric Patients:

It is frequently felt that these patients cannot participate in recreational activities due to lack of interest. The following activities have been used successfully in various hospitals:

1. Simple, modified ball games (with balls large enough or soft enough not to be a hazard).

a. Medicine ball

b. Volley ball

c. Hitting a shuttlecock with ping pong paddles.

d. Basketball

2. Cabaret style dances with tables arranged around the room for four at each table, with candles, flowers, and a night club atmosphere. Rotation dancing to encourage mixing.

3. Rhythm band — similar to children's band — using South American rhythm instruments.

4. Marching in groups to suitable music.

5. Therapeutic swimming. Swimming in water at 90°R for as long as 2½ hours twice a day. *Reference:* Nelson, Paul A., and Erickson, D. J. "Possibilities of Hydrotherapy in a Psychiatric Hospital," *Archives of Physical Medicine* 30:527 (August) 1949.

6. Gardening (flowers and vegetables) in small plots or in window boxes.

7. The use of crayons, pastels, and charcoal in sketching sessions.

C. Neuropsychiatric Patients — *NOT* Markedly Disturbed:

1. Roller skating

2. Archery for well-supervised, small, select groups.

3. Book club

4. Free pictures available from the Calendar Art Co. Variety can be incorporated by having stationary frames and rotating the pictures from ward to ward.

D. Tuberculosis Patients:

1. Bed Patients

a. Script reading — 1-, 2-, and 3-act plays.

b. Planning and conducting radio programs.

c. Bingo — with individual wards or entire hospital by using P. A. systems.

d. Contest clubs. Books available on scientific methods for winning contests.

e. Stamp collecting.

f. Pen Pal clubs.

2. Ambulatory

a. Miniature golf

b. Golf putting

c. Croquet

d. Hiking

e. Shuffleboard

f. Piano lessons

E. Orthopedic Patients:

1. Cutting records — singing or writing a letter aloud — to send home.

2. Birthday parties for individuals on wards.

3. Guessing stunts of all types. *Example:* How many peas in a jar? Or, an alarm clock in a box, set off at a time to be guessed at.

4. Egg or ping pong blowing contest.

5. Balloon volley ball.

6. Shufflette.

7. Scavenger hunts — using old magazines to find the pictures on the needed items.

8. Miniature bowling.

Evaluation of a Good Hospital Recreation Program

E. H. Pratt, *Area Director,* Special Services, Veterans Administration
Atlanta, Georgia

Evaluation in recreation is a method of determining the effectiveness and efficiency of the entire operation. It is how we determine whether hospital recreation is accomplishing its mission in the hospitals. In other words is hospital recreation contributing towards the treatment, rehabilitation and resocialization of patients?

Evaluation might be divided into five general types: objective evaluation, subjective evaluation, self evaluation, evaluation by others and evaluation of your evaluation program. Any effective evaluation program would be a combination of all five types. The important thing to remember, however, is that evaluation should be planned and should be carried out consciously. It should never be left to chance or should never be a hit or miss affair. Any recreation program that does not have as a part of its administration and supervision phase an effective planned evaluation procedure will become static and eventually lose meaning and purpose.

The more objective your evaluation program can be the more effective it will be. Objective evaluation makes it possible to not only determine the value of any program but will also establish standards and criteria for progressive improvement. For example, in evaluating the effectiveness of a sports program for NP patients the subjective approach would be to state that participation by patients was adequate and everyone seemed to be enjoying themselves. The objective approach might state that a hundred patients were in this group. Of this one hundred patients 95% were taking an active part in the activities. Twenty younger patients were participating in basketball, sixty older patients were taking part in shuffleboard and horseshoes, fifteen patients with poor contact were engaged in simple passing games with medicine balls, and five patients were simply sitting on the ground watching the others participate. The objective type of evaluation of this sports program would give the people responsible for the activity an objective way of measuring either gain or loss in participation. It gives them a goal at which to shoot, 100% participation, and enough variety and adaptations to meet the need of each individual in the group. Subjective evaluation, while having some merit, does not make for progressive improvement.

The Principles of Program Evaluation

All program evaluation must be carried out in the light of the objectives or mission of that particular program. The mission of hospital recreation is to help treat, rehabilitate and resocialize patients. This must be kept constantly in mind in setting up and carrying out evaluation procedures.

We must also set up priorities for accomplishing objectives since it is impossible to have sufficient personnel, facilities, etc., to do all the things that should be done. Priorities for accomplishing these objectives must be part of our evaluation setup. Priorities for type of patient such as NP and TB must be established. Which group of patients will receive top priority? The general type of patient group must be broken down into other cate-

gories. Will the continuous treatment patient receive top priority when it comes to recreation activities? Will we stress sports, radio or music as the best means of meeting the needs of these patients? This is all part of your planned evaluation program. There are many details too numerous to mention which must also be given consideration.

Steps in Program Evaluation

In evaluating, your program begins always with the "end product" which is, of course, the activity as it is presented to meet the patients' needs. Everything else that is done in a program, administration, facilities, planning, personnel training, all are done for the purpose of bringing an activity to patients. If you are meeting all the needs of all the patients in your hospital as determined by the medical staff then perhaps your evaluation program need go no further. If on the other hand, you find you are falling short of your mission in the hospital, then a careful evaluation of each phase of the program will make for improvement. It should be kept in mind that a balanced hospital recreation program is one which meets the needs of the patients in that particular situation. A program might consist entirely of music and be balanced; it might be all sports and be balanced; it might have none of either and still be balanced if you are carrying out your mission. Hospital recreation program balance is relative.

After determining whether or not you are meeting your objectives your program should then be broken down into all its natural phases:

a. *Staff*

Are you using your staff to its greatest advantage? Is every member assigned to take advantage of his best abilities, interests, and every hour of his work day? Is there any waste time that could be converted into patient activity time? Do you have an in-service training program for your staff members so that each may improve professionally?

b. *Facilities and Equipment*

Evaluate your facilities and equipment, not in the light of what you would like to have but in the light of what you have and can improvise. Poor facilities or equipment should never be a stumbling block to a good program. Many an outstanding program has been run with a minimum of either.

c. *Program Administration*

Check the administration of the program to see that each staff member is utilized the greatest possible number of hours in actual contact with patients. Eliminate any paper work or unnecessary details that might keep a trained employee from getting the program directly to the patient.

d. *Program Planning*

Is the program planned to meet the objectives of hospital recreation or does it just happen? Is every activity planned to contribute towards the treatment, rehabilitation and resocialization of a particular group of patients?

e. *Program Supervision*

Are your program supervisors giving constructive help? Are they able to conduct as well as observe and supervise activities?

f. *Program Operation*

The operation of your program which is the "end product" of staff, facilities, equipment, planning, administration, etc., should receive particular attention. Break the program operation up into its many parts such as

music, radio, sports, on-ward activities, off-ward activities, and establish criteria for judging them. If possible this criteria should be objective. Are you taking advantage of all community resources such as volunteer help, entertainment groups, off-station facilities, in bringing about a complete and total operation?

g. *Tools of Evaluation*

Evaluation, like any other phase of a program, can be more efficiently conducted if you have tools to help you. Various types of forms, charts and and check lists can be developed that will make it possible for you to more efficiently evaluate your program. You yourself can best develop these tools. In developing them several things must be kept in mind. First they must tend towards objectivity, they must show quality as well as quantity, and second these tools must be changed to meet a changing and improving program. Tools become static just as programs become static without critical evaluation. A mimeographed form is not the answer to program evaluation but if properly used it can be a valuable guide and tool.

Observation is another tool of evaluation. This is probably the most common type and by a little thought can become objective. It is not difficult for a recreation worker to determine the effectiveness of an activity simply by watching the results in light of what that activity is supposed to produce. Each recreation worker should be trained to watch for the things which make a program effective or ineffective. Each activity should be carefully scrutinized and criteria for determining effectiveness established.

Summary

Let me stress again that a good evaluation program is a necessary and inherent part of any hospital program. If properly conducted it will not only improve your activities but will help to make hospital recreation a real profession.

RECREATION SERVICE

A. **Previous Reports**
B. Staff (changes, needs, background & training of individuals)
C. **Facilities and Equipment** (changes, needs)
   1. Sports areas & equipment (outdoor, indoor)
   2. Recreation (indoor and outdoor, include picnic areas)
   3. 35mm booth
   4. Equipment (condition, needs)
   5. Radio
D. **Administration and Supervision**
   1. Schedules of activities (NP Master Schedules)
   2. Schedules of individual staff assignments (evaluate)
   3. Distribution of IB's and professional material
   4. Familiarity with M6-4
   5. Staff meetings
   6. Office management (filing systems, mail routing, record keeping)
   7. Method of clearance for activities (VA Form 6-7008 system for completion, overprinting, filing, etc.)
   8. Equipment storage, inventory and method of issue (6-7038 Charge Out slip)
   9. Use of activity work sheets (6-7033)
   10. Use of Recreation Activities Questionnaire (6-7043)
   11. Safety
   12. In-service training program (visits to other stations)
   13. Methods of program evaluation (patient council, polls, observation, etc.)
   14. Publicity
   15. Use of work sheet for monthly report (6-7364)

E. **Ambulatory Recreation Program**
   1. Mass analysis
   2. 35mm: Days and number of showings
      a. Pick-up and delivery of films (maintain log book M6-4, p. 16)
      b. Condition of booth and equipment (make, year, etc.)
      c. Inspection and care of films
   3. Entertainment
      a. Type and sources of outside entertainment
      b. Station produced entertainment (type, etc.)
   4. Patient participation social activities
      a. Type, quality, variety, frequency
   5. Informal recreation
      a. Available activities
      b. Supervised or unsupervised by volunteers or staff
   6. Music (number volunteers used in each phase of the program)
      a. Orchestra—number hehearsals and performances week. Volunteers
      b. Drum and bugle—number rehearsals and performances week. Volunteers
      c. Rhythm band—number rehearsals and performances week. Volunteers
      d. Instrumental lessons—number patients. Volunteers
      e. Chorus—choir, number rehearsals and performances. Volunteers
      f. Vocal instruction. Volunteers
      g. Music listening (appreciation hours, transcriptions, broadcasts)
      h. Music library: records, Stephen Foster, etc. care and storage
      i. Tape recording net work
   7. Sports
      a. Active program
         (1) Number scheduled classes per day
         (2) Number patients reached
         (3) Inclement weather program
         (3) Patient participation
         (5) Record keeping
         (6) Assignment and reassignment of personnel (staff schedules)
         (7) Coordination with CT
         (8) Storage, care and issuing sports equipment
         (9) In-service training
         (10) Self-evaluation of program
      b. Spectator program (number and type activities weekly)
      c. Off-station activities
         (1) Number patients reached
         (2) Man hours used in this phase
      d. Passive (Quizzes, pools, smokers, movies)
   8. Radio
      a. Number chanels
      b. Personnel, patients and volunteers used
      c. Use of radio for recreation activities
      d. Record storage, use, etc.
   9. Television
      a. Number sets (where located)
      b. Control procedures
   10. Tours, Outings and Picnics
   11. Newspaper
      a. Authority for publication (M6-4, p. 32)
      b. Editorial board
      c. Frequency of publication
      d. Staff hours required for each issue
      e. Patient participation
   12. Clubs and Hobbies
   13. Use of volunteers in ambulatory program
      a. Recruiting methods
      b. On-job training
      c. Supervision

F. **Ward Programs**
   1. Ward Analysis

2. Clearance methods for ward programs
3. 16mm program
   a. Number showings per week, ward coverage, etc.
   b. Use of adaptations (earphones, transparent screens, etc.)
   c. Equipment: number projectors, condition, storage
   d. Inspection care and shipment of films
   e. Use of volunteer projectionists (training, etc.)
   f. Method of clearing patients for 16mm showings
4. Entertainment
   a. Type activities (suitability)
5. Social Activities
   a. Type
   b. Planning and supervision
   c. Use of radio
6. Informal
7. Music
   a. Patient participation activities (instruction, quizzes)
   b. Listening program (individualized)
   c. Live music programs
   d. Recorded programs (use of earphones)
   e. Use of music shock therapy programs (NP)
8. Television
   a. Number for ward use
   b. Control methods
   c. Use of earphones
9. Radio
   a. Selection of programs
   b. Use of bedside recreation
   c. Patient request programs—how conducted
   d. Programs for special purposes (slumber, mealtime, etc.)
10. Newspaper
   a. Participation by bedfast patients
11. Sports
   a. Programs for bedfast patients (quizzes, movies, celebrities, etc.)
12. Clubs and hobbies for bedfast patients
   a. Type
   b. How conducted
13. Publicity
   a. Methods of informing bedfast patients regarding available activities

G. Summary

H. Recommendations

RECREATION WARD ANALYSIS

Station _____ Week of _____

CODE:
E —Entertainment (hospital or visitor show performance)
M—Music program (patient or visitor performance)
P —Party (social or game activity period)
S —Active sports period
T —Tour or Outing or Picnic
16—16 mm movie
35—35mm movie

"Confined" patients are those who are non-ambulant or are restricted to wards (locked wards) for any reason and therefore cannot go to the canteen, library, recreation hall, etc., except under supervision or escort.

Ward	Type Patients	No. Confined Patients	Recreation Activities During One Week	
			Off Ward	On Ward

MASS RECREATION PROGRAM ANALYSIS

Station _____ Week of _____

CODE: E—Entertainment (visitor or hospital produced stage show)
M—Music (band concert, stage orchestra, glee club, etc.)
P—Party (social, game, dance, etc.)
16—16mm movie (in rec. hall, theatre, outdoors, etc.)
35—35mm movie
Sa—Sport (active participation)
Sp—Sport (passive, sports quiz, sports pools, etc.)
Ss—Sport (spectator)

PLACE	Supervised Mass Recreation Activities During One Week						
	Sun.	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.

NOTES:

RECREATION & LIBRARY STAFF ASSIGNMENT SHEET

Name _____ Position Title _____ For week of _____

The time, to the nearest quarter hour, should be recorded with **brief** descriptions under the proper heading. **ADMINISTRATIVE** duties include preparation for or winding up after an activity, care of films and projectors, volunteer contacts, clearing wards, cataloging, etc. **OPERATIONAL** duties include actual conducting or presentation of activities to patients, projecting movies, on-the-spot supervision of a party put on by volunteers, book cart runs, reference work, issuing books to patients, etc.

Time (work days and hours)	ADMINISTRATIVE DUTIES	OPERATIONAL DUTIES (conducting activities)

RECREATION WARD ANALYSIS

Station _____ Week of _____

CODE:
E—Entertainment (hospital or visitor show performance on ward)
M—Music (program on ward)
P—Party social or game activity period on ward)
S—Sport (passive sport period on ward)
16—16mm movie (on ward)

"Confined" patients are those who are non-ambulant or are restricted to wards for any reason and therefore cannot go to the canteen, library, recreation hall, recreation lounge etc.

Ward	Type Patients	No. Confined Pats.	Recreation Activities on Wards During One Week						
			Sun.	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.

Sun.			Mon.			Tues.			Wed.			Thurs.			Fri.			Sat.		
AM	PM	Eve.	AM	PM	Eve.	AM	PM	Eve.	AM	PM	Eve.	AM	PM	Eve.	AM	PM	Eve.	AM	PM	Eve.

SELF-CHECK LIST FOR CHIEF, SPECIAL SERVICES

Year _____

PROJECT	Put in (√) or date, or other notation each time project is accomplished.											
	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
ADMINISTRATION File of IB's, T.B.'s etc. current.												
New publications discussed with hosp. staff.												
Publicity received from each section.												
All reports submitted.												
Chief at Manager's staff meeting.												
SS staff meeting.												
Mail handling reviewed.												
Follow-up any policy change.												
Office equipment condition.												
Inspected safety hazards.												
Follow-up supervisory recom.												
All SS positions filled.												
Pos. Descrip. current.												
Efficiency ratings done.												
Sections submit req.												
Follow-up req.												
84-4 funds discussed.												
Group 40 budget submitted.												
G.P. Fund balance.												
Area Director informed of fund needs.												
Depot items checked with S.O.												
SS sup. & equip. inventory.												
Surplus equipment.												
Cigarettes control.												

SELF-CHECK LIST
CHIEF, SPECIAL SERVICES

Year

PROJECT	Put in (√), or date, or other notation each time project is accomplished.											
	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
PLANNING & COORDINATION Reviewed overall SS plans.												
Rec. plans reviewed.												
Lib. plans reviewed.												
Chap. plans reviewed.												
Cant. plans reviewed.												
VAVS plans reviewed.												
VAVS meeting planned.												
Review plans with: Manager												
Chief, Prof. Serv.												
Chief Nurse												
Finance Officer												
Supply Officer												
Engineering Officer												
SUPERVISION AND EVALUATION Accompany book cart.												
Accompany canteen cart.												
Attend chaplaincy program.												
Visit ward rec. activity												
Visit sports activity.												
Visit rec. hall activity.												
Visit club or hobby program.												
Observe radio program.												
Attend outing or tour.												
Attend 35mm. showing.												
Observe 16mm showing.												
Review placement of TV sets.												

SELF-CHECK LIST FOR CHIEF, SPECIAL SERVICES

Year

PROJECT	Put in (√) or date, or other notation each time project is accomplished.											
	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
SUPERVISION AND EVALUATION (continued) Indiv. conf. with SS employees												
Review employees work schedules.												
Review hours of operation: Library												
Canteen												
Recreation												
Check pers. serv. oper.												
Check delegation of authority.												
SS employees observed in action												
Patient council meeting.												
Patient interest survey.												
Evaluation by medical.												
TRAINING Initiated in-service training: Rec. employees												
Lib. employees												
Volunteers in SS												
VAVS discussed with: Chief, Prof. Serv. and staff.												
Chief Nurse & staff												
PM&R staff												
Social Service												
Dietitian												
Manager												
New hosp. employees												
Individual vols.												
O & I course need.												

Group Sessions

1 Federal Hospitals

C. C. Bream, *Chairman*

Personnel Standards, Qualifications, and in-service training were the main topics discussed during the Federal Hospitals Session Thursday evening, May 21, 1953. In the discussion on Personnel Standards and Qualifications, reference was made to the following publication of the Civil Service Commission:

a. Veterans Administration Probational Requirements dated March 30, 1953 for recreation leader, recreation supervisor and recreation director.

b. Recreation Series 188-0 dated, February 1951 of the Federal Civil Service Commission.

In reviewing the Veterans Administration Probational Requirements, the following major points were discussed:

a. Options covered that included dramatics, radio, sports, social activities and services, music, arts, crafts, and general activities.

b. Education and experience requirements for Federal Grade levels of GS-3 to GS-14.

It was pointed out that one year experience in one or more of the above listed options or an educational equivalent was necessary for a GS-3 grade. For a GS-4, two years; for GS-5, three years, and for a GS-6 and above, progressive experience as indicated below:

	Years of Experience Required	
Grade	*Total*	*Supervisory or Administrative*
GS-6	½	None
GS-7	1	½
GS-8	1½	¾
GS-9	2	1
GS-10	2½	1½
GS-11	3	2
GS-12/14	3	3

It was also pointed out that all the required experience for the sports option and at least one-half of the required additional experience for all other options must have been with hospitalized or handicapped persons.

In addition, the educational requirements for the specific options were discussed at great length. In this connection, it was pointed out that successful completion of a full four year course of study in residence school above the high school level including or supplemented by at least 24 semester hours in courses appropriate to one of the options, could be used in lieu of the experience requirement for GS-5. In summing up this phase of discussion period, all personnel were encouraged to obtain a copy of the Veterans Administration Probational Requirements for recreation leader and supervisor in order that an intimate knowledge of technical and specific details involved might be more easily understood.

In the discussion of the Recreation Series GS-188-0, it was pointed out that this series covered recreation administrators, directors, supervisors and

staff workers, who although they may not be engaged in direct leadership activities, nevertheless discharged duties or responsibilities in connection with the recreation program which requires the use of specialized knowledge concerning recreation policies, plans, aims, procedures, tools, techniques and methods. The group was informed that certain positions that might be considered by some recreational in nature, were not covered by this publication. For example, positions, the work of which is incidental, related or contributory to recreation leadership activities, such as life guard at pools and beaches, artisand, maintenance personnel, and *operators* of radio or video transmission machines or motion picture projection machines in Veterans Hospitals.

The group was informed that the absence in the GS-188-0 series of specific grade allocations GS-4, 6, 8, or 10 was not to be interpreted as meaning that allocation in these grades could not be made. If a job description was stronger that a GS-5, but weaker than a GS-7, it could possibly be allocated to the GS-6 level. The differentiation between the three major titles used in the series was discussed, namely leader, supervisor and director. Basically, the leader is recognized as an individual responsible for a specific activity as opposed to the supervisor whose major responsibility consisted of the supervision and administration of the operation and conduct of specific recreation program specialities. Here again, the group was urged to obtain a copy of Recreation Series 188-0 in order that they might study the many specific and technical aspects of this Federal publication covering recreation positions for which salaries are paid for from funds appropriated by the Congress of the United States.

The Recreation Series GS-188-0 is available at the Government Printing Office, Washington 25, D. C.

The discussions of this group were concluded with stimulating contributions from all concerning in-service training. It was agreed that an effective in-service training program must have a definitely stated objective and a plan for its conduct and operation. It was agreed that in-service training would be most meaningful when the following methods of conduct were included:

a. Staff Meetings
b. Work Shops
c. Individual Conferences
d. Rotation of Professional responsibilities
e. Observation and evaluation
f. Attendance at medical lectures
g. Reading of literature and other resource material

The question of including personnel other than the professional staff in staff meetings was concluded by agreeing that the purpose for which the staff meeting was called would determine the personnel invited to attend. For example, staff meetings at which confidential information or policy development would be the major topics should be attended by the professional staff only. On the other hand, volunteers would be invited to attend during certain program planning sessions.

Workshops proved valuable and could be limited to the professional personnel of the staff or others who might be scheduled to participate in the program depending upon the purpose for which the work shop was organized.

Individual conferences were considered extremely valuable for making detailed analyses of specific jobs and at the same time for candid discussions of strong and weak points, of an individual. While it was recognized that considerable time was involved in the conduct of individual conferences, it was agreed unanimously that they were very important and one of the most effective ways of increasing the value of an individual's contribution to the program when conducted in a frank and honest manner.

The rotation of professional responsibilities would include visits to other hospitals as well as periodic assignments involving new and different responsibilities for staff personnel at the hospital where employed. It was recognized that this rotation of responsibilities should be attempted only when the recreation director had accomplished a thorough review of the experience and background of the individual concerned in order to make certain that the program would not be reduced in effectiveness through such a procedure.

Observation and evaluation was considered a MUST, particularly for the recreation director if his supervision of the program was to prove effective. It was agreed that evaluations of an individual's contribution to the program would prove most beneficial when accomplished by the recreation director as soon as possible after observing the individual concerned. At the same time, general evaluation of the over-all program would lend itself admirably to a staff meeting at which all of the professional recreation staff would be in attendance.

Attendance at medical lectures was agreed to be one of the best possible means of preparing the staff for consultations with ward doctors, and other physicians. Through this means, medical terminology and its meaning would be better understood and contribute to move intelligent understanding by all concerned.

It was agreed that all recreation personnel should find time and be cognizant of the sources for appropriate literature and resource material. Through this media, new adaptations and techniques would be learned as well as addition to program techniques and ideas for incorporation in the specific or over-all recreation program could be determined.

II State and Private Hospitals

(A Panel Discussion)

C. N. Carroll, Director of Recreation, State Hospital, Raleigh—Presiding

Mr. Carroll expressed the desirability of recreation departments having good working relationships with all other departments of the hospital; doctors, nurses and occupational therapists.

Mrs. Beatrice H. Hill, Consultant to Recreation Rehabilitation Service, City of New York.

Trends in New York City Municipal Hospitals, regarding recreation programs were discussed. Six years ago all of the recreation in these hospitals was handled by volunteer groups with no professional workers. Today there are 51 professional recreation workers in New York City Hospitals.

One of the rehabilitation centers has four professional recreation workers. Bellevue Hospital has nine and an additional 100 volunteers who work with the children.

Dr. Ellen Winston, Commissioner of Public Welfare for North Carolina, Raleigh.

Factors Concerning the Planning of Hospital Recreation Programs: There is wide range in what is now being done in the way of planning for hospital recreation programs, especially so when both State and private mental hospitals are taken into account. Whatever the institution or auspices, it is important that the major emphasis be upon the patient himself. We need to start with the patient in terms of his needs and his history. After all, he has engaged in recreation in the past and we must be conscious of his own interests and habits. Planning for recreation for the patient is not something done to him but *with* him. Again placing the emphasis upon the patient, we need to be concerned as to how recreation activities may help him to get better and how it may be related to the total getting well processes. Any recreational activities should be evaluated in terms of their therapeutic and rehabilitative values for the individual concerned. Will they speed recovery? Will they help the individual adjust to his illness, to hospital life? Recreation in the State Hospitals is not mass produced.

Having started with the patient, we next need to evaluate how the professional staff sees a recreational program. Does the medical staff and the nursing staff see the benefits to patients and are they able to utilize a recreational program effectively? The services of the medical staff are definitely needed in helping the recreational staff understand the individual needs of patients and ways in which the program may be more effectively geared to those needs.

As in most programs, money, space and equipment are all important factors. Some hospitals are much better off in these respects than others, but even where these three factors are limited, there is the question of whether the recreational staff makes the best utilization of the funds, the space, and the equipment available, as well as the extent to which skills are applied to give the greatest help to patients. It is of paramount importance that the recreation staff have ability to understand the reactions of the patients and to plan programs in relation to individual needs.

Another important factor concerning planning for hospital recreation is ways in which the community may be brought into the hospital. There are many opportunities for well organized volunteers.

In all of these aspects of planning for recreation the timing of individual activities in relation to the patient's progress is tremendously important. This calls for great sensitivity on the part of the recreation staff.

Perhaps in planning for hospital recreation programs, the quality to stress most is imagination — imagination with regard to adapting recreational skills to the needs of patients, imagination in terms of helpng the patient utilize most effectively the recreational opportunities an institutional setting presents, imagination in gearing the recreation program to the medical program for the patient so that there may be an integrated approach to helping him benefit most from the hospital experience.

Mrs. W. K. Beichler, Chairman, Wake County Gray Ladies, Raleigh, N. C.

7,900 volunteer hours have been given in the past year.

Some of the areas of service include:

1. Work with post-lobotomy female patients at the State Hospital in Raleigh. An attempt to bring normal activity to the wards is made in using music, playing cards and other games with the patients.

2. Give a party at the Veterans Hospital in Fayetteville one day each month, and

3. Help with blood drives.

Dr. Marian M. Estes, State Hospital, Raleigh, N. C.

The hospital program should be patient centered. Every patient should get all available treatment every day. These things are important:

1. There is a challenge in working with patients who are out of contact. Preoccupied people must be stimulated to get them into activity — barriers must be lowered — the worker must give a part of himself and play with these patients.

2. Recreation must be graded in order to meet the needs of the patients. A competitive situation, for example, may be traumatic to certain patients.

3. Recreation workers should know some of the problems of the patient in order to understand the treatment goal.

4. Recreation workers should be constantly aware of the acute sensitivity of the patient, regarding the feelings of the worker for the patient.

Reverend Charles N. Hubbard, Summarizer, Raleigh, N. C.

1. Recreation is becoming more important every day.
2. Professional recreation in hospitals is a pioneer field.
3. Recreation is no cure-all.
4. We need pioneer writers and publishers of hospital recreation literature.
5. Cooperate and get the support of the American Medical Association and the American Psychiatric Association regarding hospital recreation.

A Selected Biography on Hospital Recreation

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For specific information relative to recreation in military hospitals write to Miss Lillin A. Summers, National Recreation Consultant, Service in Military Hospitals, The American National Red Cross, National Headquarters, Washington 13, D. C.

For specific information relative to Recreation in Veterans Administration Hospitals write to: Assistant Administrator for Special Services, Attention: Director, Recreation Services, Veterans Administration, Washington 25, D. C.

compiled by: North Carolina Recreation Commission
134 Education Building Annex
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May 1953

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Report of Social Recreation Institutes—1950

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Reprints and Addresses

A Midcentury Declaration of Recreation Policy—National Recreation Policies Committee—1950

Starting An Industrial Recreation Program—Carl Skillman—1946

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Recreation for Towns and Villages—Theresa S. Brungardt—1950

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